AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE	**Meeting Date: September 20, 2012** **Time: 10:00 AM** **Location: 125 Worth Street, Room 532**

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-July 19, 2012

CHIEF MEDICAL OFFICER REPORT — **DR. WILSON**

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEM:

1. Resolution authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a contract with Epic Systems Corporation for an Enterprise-Wide Electronic Medical Record (EMR) System including the software license, installation, training and maintenance to be used throughout the Corporation's facilities. The contract Will be for an initial term of ten years, with an additional five-year renewal option, exercisable Solely by the Corporation, in an amount not to exceed $302,807,986. — **MR. ROBLES/ DR. CAPPONI**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: July 19, 2012

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN
Vincent Calamia, MD
Christina L. Jenkins, MD
Amanda Parsons, MD (representing Thomas A. Farley, MD)

HHC CENTRAL OFFICE STAFF:

Donna Benjamin, Restructuring Project Manager
Beth Brooks, Assistant Director, Patient Centered Care
Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Frederick Covino, Assistant Vice President, Budget Reporting
Juliet Gaengan, Senior Director, Clinical Affairs
Evelyn Hernandez, Director, Media Relations
Caroline Jacobs, Senior Vice President, Safety & Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Ambulatory Care Transformation
Mei Kong, Assistant Vice President, Patient Safety
JoAnn Liburd, Senior Director, Accreditation & Regulatory Services
Patricia Lockhart, Secretary to the Corporation
Tamiru Mammo, Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Kathleen McGrath, Senior Director, Communications & Marketing
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
Joseph Quinones, Assistant Vice President, Contract Administration & Control, Operations
Salvatore Russo, General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Health Care Improvement
Joyce Wale, Senior Assistant Vice President, Behavioral Health
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs
Marlene Zurack, Chief Financial Officer

FACILITY STAFF:

Steven Alexander, Chief Operating Officer, Bellevue Hospital Center
Abha Agrawal, MD, Medical Director, Kings County Hospital Center
Chris Constantino, Executive Director, Elmhurst Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Iris Jimenez-Hernandez, Senior Vice President, Generations +/Northern Manhattan Network
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Meryl Weinberg, Executive Director, Metropolitan Hospital Center
Julius Wool, Executive Director, Queens Hospital Center

OTHERS PRESENT:

Jugal Agarwal, Chief Financial Officer, Atlantic Dialysis Management Services, LLC
Leon Bell, Associate Director, New York State Nurses Association (NYSNA)
J. Ganesh Bhat, Principal, Atlantic Dialysis Management Services, LLC
Mayette Casco, RN, Vice President, Clinical Affairs, Atlantic Dialysis Management Services, LLC
William D. Cundiff, Vice President, Regulatory Affairs, Atlantic Dialysis Management Services, LLC
Teresita de Guzman, RN, Administrator, Springfield Dialysis Center
Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Gloria Luis, RN, Chief Educator, Atlantic Dialysis Management Services, LLC
Jeanne Madadsec, RN, Administrator, Central Brooklyn Dialysis Center
Nirmal Mattoo, Principal, Atlantic Dialysis Management Services, LLC
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management and Budget
Ron Pascual, RN, Administrator, New York Renal Associates
Judy Wessler, Director, Commission on the Public's Health System

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, July 19, 2012**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:12 A.M. The minutes of the June 14, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer reported on the following initiatives:

1. Microsoft Care Plan Management System

Contract between HHC and Microsoft Corporation for the development and implementation of a Care Plan Management System, including software licenses, a patient health record and support and maintenance was executed this month. The System will ensure that HHC meets New York State (NYS) Health Home certification requirements and Patient Centered Medical Home (PCMH) standards for collaborative care planning by supporting care coordination services for Corporation patients throughout the five boroughs of New York City. The system is a web-based, inter-operable tool that aids both patients and their extended care teams in managing and coordinating the medical and non-medical services and resources patients may require. Once implemented the Care Plan management System will ensure that HHC meets NYS Health Home certification requirements and PCMH standards for collaborative care planning. The term of the contract with Microsoft is for five years, and is renewable for two additional one year terms. The software license is perpetual and the annual maintenance and support agreements are auto-renewable. The total cost of the contract over the 7 year period is capped and will not exceed $16,100,000. The contract was successfully developed with the collaboration of HHC IT, Office of Ambulatory Care Transformation and Office of Legal Affairs.

2. Hospital -Medical Home Demonstration (H-MH) Project

HHC submitted applications for the New York State Department of Health Hospital-Medical Home (H-MH) Demonstration Program on behalf of our 11 hospitals on July 2, 2012. The H-MH Demonstration Program will make up to $250 million available over the next three years to NYS teaching hospitals to support transition of their outpatient training sites to PCMH. If successful, HHC is estimated to receive approximately $28 million of the $102 million to be disbursed in the first year of the demonstration, based on a formula derived from Medicaid volume and number of primary care residents receiving training at our facilities. Award notifications are expected sometime in August and successful applicants will then be required to submit a work-plan describing selected resident training continuity of care enhancements, care integration initiatives, and inpatient safety projects. Continued funding will be dependent upon meeting certain performance milestones, including achieving Level 2 or 3 NCQA PCMH re-certification by December 2013. Contract with Microsoft for Care Plan Management System executed.

3. HHC Health Home

As announced last month the Health Home "soft launch" was initiated this week in the boroughs of Brooklyn and The Bronx with activities for both patients and staff. Announcement letters describing the new program and its services and providing instructions on how individuals should proceed with enrollment were sent out to 200 eligible patients and HHC Health Home our Warm-Line was activated and is ready to provide

information about the Health Home Program to callers. Also, a second phase of training focusing on outreach, patient enrollment and care coordination processes was conducted for approximately 20 staff members from Woodhull, Kings and Lincoln hospitals. Six workers are ready to conduct outreach to the 200 patients we've notified and, given our experience in the NYSDOH Demonstration Program with a similar population, we plan to successfully enroll about 25% within the next four (4) weeks.

4. Sixth Annual NYC Peer Specialist Conference – Office of Behavioral Health

Today, (Thursday, July 19, 2012) Joyce Wale, Sr. AVP, Office of Behavioral Health, provided opening remarks for the Sixth Annual New York City Peer Specialist Conference. This years' conference titled *Redesign by Design: Healthcare Reform and the Role of Peers* is focused on the ways that individuals whom have reached a point in their recovery can help others and become part of the treatment team. Over the years HHC has won awards for our work in using Peer Counselors and most recently provided workshops on the use of Peers in discharge planning and as Health Coaches in our Keeping Healthy After Hospitalization groups.

5. Office of Patient Centered Care

There were two events recently focused on the culture change needed to improve the experiences our patients have while in our care. On June 27th HHC worked with the NAPH and three other safety net organizations on some facility-based initiatives designed to engage staff at every level, fostering respect for all. This collaborative will continue through the fall, with teams reporting in their progress in experimenting with change. The second event was July 11th, when an expert from our new partner, Press Ganey, came and met with our senior leaders about their role and influence in fostering the real and lasting culture changes required. Discussions continue regarding next steps.

6. FEMA Reimbursement – Hurricane Irene

The HHC Office of Emergency Management recently concluded working with FEMA's Public Assistance Program to obtain reimbursement for expenses incurred in preparation for and response to Hurricane Irene. Expenses considered reimbursable included mitigation measures taken to prepare the facility for the hurricane, staffing for personnel assigned to the Special Medical Needs Shelters or performing hurricane related tasks outside of their normal duties, supplies and equipment provided to the Shelters, costs related to the evacuation of Coney Island Hospital and damage to facilities caused by the hurricane.

HHC facilities estimated total expenses (OTPS/PS/Damages) to be $8,600,140 of which $4,165,000 was for damages to facilities. FEMA approved $2,805,896 in reimbursements of which $1,207,506 was for damages and debris removal. HHC will receive $2,455,159 (87.5% of the approved payment).

CHIEF INFORMATION OFFICER REPORT

Mr. Bert Robles, Chief Information Officer was unable to attend. His report was submitted for the record as follows.

1. EITS is a Finalist in the "Where to Work: Best Hospital IT Departments" Survey

HHC EITS is a finalist in the "Where to Work: Best Hospital IT Departments" survey sponsored by ***Healthcare IT News***. The objective of the survey is to identify the top 25 hospital IT departments across the

country that are the most desirable places to work – and the unique qualities that make them so. Of the 277 nominated hospitals, EITS is one of the 125 IT departments that have qualified for one of the top 25 spots. In order to qualify, 52% or 440 EITS staff completed a 67-question online survey. EITS staff graded their department across seven (7) categories: day-to-day work, IT team, management, hospital leadership, workplace culture, training and development and compensation.

All of the finalists will receive a benchmarking report showing how well they ranked in different areas as compared to their competition. The top 25 hospital IT departments will be profiled in an October 2012 special report distributed by ***Healthcare IT News*** in print and also published on-line. I'll keep the committee posted on how EITS does.

2. Enterprise Single Sign-On (eSSO) and Self-Service Password Reset (SSPR) Project

The EITS Corporate Applications team is working to complete deployment of Oracle's Enterprise Single Sign-On (eSSO) and Self-Service Password Reset (SSPR) tool. Estimated completion for all of HHC staff to have eSSO / SSPR deployed on their workstations is on target for December 2012.

Presently eSSO / SSPR pilots are underway at all HHC Networks. Pilots generally start with local IT staff and then are pushed to designated users throughout the facility. These tools have been fully deployed at the Enterprise Service Desk. Corporate Applications regularly meet with ESD staff to provide follow-up regarding questions or issues encountered with user support.

There are a total number of 505 pilot users and as of July 6th there are over 2300 active users for these tools. Currently, there are 83 Core Applications on Single Sign On – with many more being requested to be built today. Corporate Applications estimates that once fully deployed, eSSO/SSPR will save HHC about $3,558,000/year.

3. Update on Windows 7 Encryption and Back-Up

In April 2012 Enterprise Information Technology Services initiated a project to upgrade all desktop and laptop computers across the Corporation to Windows 7 and Office 2010. To ensure the workforce is familiar with the new features associated with this upgrade we are conducting a 90-minute mandatory orientation class which highlights the differences between Windows XP and Windows 7 and Office 2003 and Office 2010 prior to users getting upgraded. As of July 13, 2012 we have upgraded approximately 8,600 out of 33,000 desktop and trained approximately 11,300 out of 44,000 employees. Percentage wise this 25% of our desktop and employees trained within 3 months of this project. We are on target to finish this project on or before June 2013.

In an effort to ensure HIPAA compliance and to protect sensitive data including ePHI from unauthorized access resulting from a loss or theft of a desktop, laptop, or any other removable media device, Enterprise IT Services also initiated an enterprise encryption project in conjunction with the Windows 7 project. To date we have encrypted over 9,000 workforce computing devices and have also standardize encryption on any removable media device. We also anticipate this project being completed by the 2nd quarter of 2013 which will significantly improve our security posture and lower or risk of any sensitive or protected health information failing into the wrong hands.

4. Status of Enterprise Encryption of System Back-Ups

As mandated by Operating Procedure 250-16 and 19, the corporation backup policy includes a requirement that we encrypt backups for all systems containing electronic Protected Health Information (ePHI) and confidential information that are sent to off-site storage in event of disaster. At the present time, we are encrypting 862 out of 888 (business and clinical) systems which means 96% of electronic patient health information and confidential files are secured. For the remaining 4% (26 systems), there are a series of issues stemming from old technology and applications which do not support encryption to the Food and Drug Administration regulated software and hardware. FDA regulated equipment will not allow non-approved software to be installed unless it is first tested and approved by the FDA which can be a lengthy process. We are currently working with non-compliant vendors to explore different options, such as application version upgrades and architectural changes to their application, which will allow us to incorporate the backup of those systems into our Enterprise Backup Environment.

5. Update on Networking Infrastructure Refresh Program

In February 2011 the Board of Directors approved a capital spend of $25.3 million for a network infrastructure refresh program. This funding was to be used to upgrade and maintain the first phase of a five (5) year network infrastructure refresh program to assist the Corporation in accommodating application growth, increasing bandwidth for faster application response times and maintaining stability. This program is essential in order to support new initiatives and technologies such as a new EMR, Meaningful Use, Business Intelligence, Soarian, Picture Archiving and Communication System (PACs) and Data Center Consolidation to name a few.

To date, Infrastructure and Operations has encumbered purchase orders totaling $20.5 million and is on track to spend the remaining balance by end of Calendar Year 2012. EITS will be requesting additional funding from the Board of Directors for Phase II of the Network Refresh Program and has estimated that it will cost $40-45M. One hindering factor to the progress to this program has been the readiness of the environmental requirements at the facilities (power and cooling). These physical and environmental dependencies have slowed down the program's pace.

6. PC Refresh Program Update

In December 2011, the Board of Directors approved $8.8 m in a PC Refresh Program. The Board requested that we provide an update as to the status of this program. To date, EITS has spent $ 5.2 million in PC purchases for the facilities.

7. Storage Refresh Program Update:

Also, in December 2011, the Board of Directors approved $6.0 million for a Storage Refresh Program and requested that we provide an update. To date, a total of $1.0 million has been encumbered.

8. EMR Negotiations Update

We are currently in negotiations with two (2) vendor finalists. Mr. Robles expect's to bring the new EMR contract to the August 1st Contract Review Committee and to both the September M&PA/IT Committee and the full Board meetings.

METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of June 29, 2012 was 435,223. Breakdown of plan enrollment by line of business is as follows:

Medicaid	367,338
Child Health Plus	16,291
Family Health Plus	36,830
MetroPlus Gold	3,130
Partnership in Care (HIV/SNP)	5,827
Medicare	5,807

This month, MetroPlus added 2,190 members. Their largest growth was in their Medicaid line of business.

Month over month, MetroPlus' membership in Child Health Plus has experienced a steady decline since the beginning of the year. This year, they have lost 12.6% of their membership in Child Health Plus. The loss of membership is attributed to their membership aging out and losing eligibility for this product. These members convert from CHP to Medicaid due to changes in financial status.

Dr. Saperstein provided reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. This month, MetroPlus added 154 new enrollees in Medicare, with the largest growth in their Advantage (Dual- Eligible) product.

As Dr. Saperstein reported last month, the New York State Department of Health (SDOH) has provided a draft of the Phase 1 pharmacy rate change analysis. The total rate change for Medicaid in NYC was -7.1%. The total rate change for FHP in NYC was -11.5%. For MetroPlus, this amounts to approximately three million dollars less in pharmacy revenue per month. The New York Health Plan Association has expressed ongoing concerns about the inadequacy of pharmacy rates. HPA questioned several of the assumptions that were used by Mercer, the SDOH's actuary, to develop the new rate. As a result, Mercer has committed to review the data again and to continue the discussion around the decreased rate change. Dr. Saperstein will continue to keep the Committee informed as discussion around this topic continues.

The 2013 Medicare Bids were submitted to CMS on June 4, 2012. The MetroPlus bid is now in desk review with CMS. We expect to know if CMS will require material changes to our proposed submission by the end of the summer. Additionally, in the earlier part of the year, CMS identified the Plan to undergo a financial audit and we are in the process of preparing the data submission that is due on July 27, 2012. CMS will perform an onsite review in August.

As Dr. Saperstein reported earlier this year, as of July 2, 2012, all Medicaid managed care plans will be required to cover dental services for their enrollees. The MetroPlus dental implementation is going well and the transition has gone smoothly. We have contracted with Healthplex to administer dental benefits for all our MetroPlus Medicaid and Medicaid SNP members. Also as of July 2, 2012, MetroPlus Family Health Plus, Child Health Plus, and Medicare Advantage members will have management of their dental benefits transition from DentaQuest to Healthplex.

MetroPlus continues to work very closely with HHC towards the successful implementation of the HHC Health Home. The go-live date for the start of membership outreach is July 16, 2012. MetroPlus is ready to perform the initial mailing and route calls to HHC for handling. Currently, we are awaiting HHC's signature of the Health Home contract. We hope to have this contract signed in July.

Mandatory enrollment for Managed Long Term Care (MLTC) began on July 2, 2012. CMS has provided the state verbal approval for this change, and New York Medicaid Choice has started sending notifications to approximately 500 recipients in Lower Manhattan. The MetroPlus application for a MLTC License was completed and submitted. Representatives from the NYSDOH will be onsite on July 10, 2012 for the MetroPlus readiness review. Dr. Saperstein anticipates that the readiness review will conclude successfully and MetroPlus will be granted a license.

This summer, MetroPlus will continue to meet with all network and facility leadership in regards to our strategic initiatives to grow the Medicare product. As of June 29, 2012, we have had three successful meetings in order to build the internal processes and systems needed to facilitate potential enrollment of the nearly 22,000 dual eligible patients in HHC.

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract with Atlantic Dialysis Management Services LLC ("Atlantic") to provide dialysis technical services to HHC patients in the following facilities: Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, North Central Bronx Hospital, Queens Hospital Center, and Woodhull Medical and Mental Health Center. The contract shall be for a period of five years with one, four-year option to renew exercisable solely by the Corporation, in an amount not to exceed $83 million for the entire term of nine years.
   AND
   Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer and Lauren Johnston, Senior Assistant Vice President/Corporate Chief Nursing Officer, Office of Patient Centered Care, Division of Medical & Professional Affairs. Dr. Wilson began the presentation by noting that the provision of dialysis services has a significant and ongoing financial threat to HHC's budget now and in the outer years. HHC faces an on-going and expanding need to provide inpatient and outpatient dialysis services; with some patients having to continue as inpatients in order to receive chronic dialysis treatments. Facility, equipment and personnel expenses continue to rise. Regulatory agencies are raising their standards and compliance will necessitate additional investment while revenues do not come close to covering current costs. Although dialysis is an important clinical service for our patients, we currently are losing $24M annually providing the service. Also, we are currently unable to provide outpatient dialysis services to all patients who need the service. Capital needs for current facilities continue to increase which HHC continues to struggle with given its current financial status.

The first and foremost deliverable the vendor must adhere to is to ensure access to dialysis treatment for all ambulatory patients, regardless of insurance status and that no patient will have their dialysis delayed or denied because of their immigration or financial status. The second thing we require from the vendor is a fully licensed and compliant site within our facilities, with an HHC nephrologist as Medical Director ensuring policies and oversight of the conduct of the dialysis center by HHC staff. The third component is 24 hour, 7 day per week acute dialysis service for inpatients.

Strategies to maintain the quality of service over the period of time firstly is to make sure that the patients continue to be managed by their HHC nephrologist. Care will be provided in a manner that meets or exceeds all required standards - internally and externally reported indicators will be monitored and publically available. HHC has had successful experience from this vendor at Elmhurst Hospital Center for the past six (6) years with excellent quality services. We also note that 80% of United States hospitals have elected to outsource their dialysis services to date on the basis of being able to maintain quality while reducing costs.

When looking at the summary of financial projections over the nine years we are projecting a contract cost of $83 million (acute dialysis fee for service payments = $65M; chronic patients ineligible for any insurance = $18M) with a projected savings of $147 million derived by the following:

Dialysis cost avoided	$245M
Rental income from licensed space	$14M
HHC staff attrition costs over 5 years**	($29M)
Total contract cost (per above)	($83M)
Total Projected Savings	**$147M**

The next slide of the presentation summarizes the discussion at the Capital Committee of the Board which resolved the requirements of annual license fees for leased space for chronic dialysis as follows:

Facility	sq ft	cost per sq ft
KCHC	8970	$54.00
MHC	5015	$50.00
HHC	9260	$50.00
LMMHC*	5998	$40.00
NCB*	6825	$40.00

New units will be built at North Central Bronx (NCB), where none has existed, and a larger unit at Lincoln Medical and Mental Health Center, where patients are routinely referred out due to lack of capacity. The vendor will apply to obtain the Article 28 licenses and all HHC sites will relinquish their licenses to provide chronic service. Along with construction this process will take one to two years to complete. These are the minimum space allocations – up to 9,000 sq ft may ultimately be identified and leased. Equipment has been inventoried, will be purchased at depreciated value and replaced with new fleet of machines.

Dr. Wilson concluded the presentation by stating that the resolution before the Committee is about outsourcing acute and chronic dialysis services in a way that leads to maintaining or improving quality of care, a method of improving access to services for everybody in a way that leads to reduction in costs with no lay off of HHC staff members.

Moira Dolan, Senior Assistant Director, District Council (DC) 37 Research & Negotiations Department, on behalf of Lillian Roberts, Executive Director, and members of DC 37 presented the unions position on HHC's proposed dialysis privatization plan.

Ms. Dolan noted that the vendor will achieve savings by reducing staffed hours per patient from the current 1.67 hours per patient day to 1.33, a 20% reduction. The fully privatized model reduces the registered nurse hours per patient for both chronic out-patient and acute patients. Reduced staffing with high needs patients will affect quality. The turnaround time for the stations will be reduced and there will be less supportive services for the patients. Ms. Dolan pointed out that four Atlantic Dialysis Management centers currently operating in New York City scored "worse than expected" patient outcomes in a recent study (Medicare.gov Facility Compare quality data through December 2010) with higher mortality rates.

Ms. Dolan implored the Committee to reconsider the privatization plan.

Leon Bell, Associate Director, New York State Nursing Association (NYSNA) will speak to NYSNA's opposition of the privatization plan.

Safe registered nurse staffing levels and adequate RN hours per patient day are critically important in ensuring patient safety and in reducing adverse patient outcomes. The reduction in the staff skill mix and in total RN staffing proposed by the NYC Health and Hospitals Corporation, through transferring its dialysis services to the for-profit Atlantic Dialysis Management Services, will have a direct, negative effect on the quality of care that patients will receive. The population of chronic out-patient and acute in-patient dialysis patients are medically fragile, have multiple co-morbidities and require frequent and ongoing assessment. Research studies clearly demonstrate that improved nurse staffing levels reduce adverse outcomes and saves patient lives.

In an ongoing commitment to public policy that improves access to quality health care for New York's residents, NYSNA opposes the transfer of HHC dialysis services to a private, for-profit provider.

Dr. Stocker stated that we are four years into a prolonged effort to make HHC as cost effective as possible without compromising patient care. HHC has been judicious in trying to save dollars without hurting patient care. As noted earlier, 80% of United States hospitals have elected to outsource their dialysis services to date on the basis of being able to maintain quality while reducing costs. There is an intense security of outsourced dialysis nationally with measures to track quality of services. Finally, dollars saved here can be used to take care of other people that have other medical needs

Dr. Wilson responded that he would briefly focus on the comments made about the quality of services and to share the interest of the speakers focus on quality of care. HHC, in fact, is also very concerned about the quality of care and our ability to continue to maintain or improve performance and services. With respect to the report noted by one of the speakers, one of our current HHC sites has a score of under 20, and one of the Atlantic sites has a score of under 20. We did asked the vendor to review and share with us their detailed understanding of what was going on at that site. Our summary of that investigation was that there shown improvement, but still not at the level to get them over 20%, however moving in the right direction. The patient survival figures in the quality data are as much affected by the patients underlying diseases and age as they are by the adequacy of dialysis. If you have a large number of older patients or patients with three or four chronic illnesses their survival from their diseases are going to be mixed – so the survival figure taken on the face value needs a significant risk adjustment to be an adequate measure of the dialysis services. Of the indicators in the referred to report the one measure that shows the adequacy of dialysis is the "percentage of patients who had enough waste removed from their blood during dialysis". So if the dialysis is conducted in a technical way which is inadequate that doesn't mean the obvious – there are many factors, such as it was

the wrong dialyzer, not enough time on dialysis, etc. - the adequacy of dialysis is publicly reported and scrutinized. The overall supervision of the dialysis from our point of view by an HHC nephrologist appointed as the medical director at each of these delivery sites affords us the ability to manage and control issues (process, equipment, patients) and have an active role in the decision making process for correction. We appreciate the detailed information, and appreciate the highlighting of where things are not quite as we would like them to be. We believe on balance that the quality and the services being provided is at or above what we require as a team to go in the right direction and within the context of the contract and quality issues or poor patient care will be dealt with promptly.

Dr. Amanda Parsons stated that she appreciates how difficult this decision has been for HHC. Some of her concerns were addressed throughout the presentation, one of which was the fact that the medical leadership will be retained by HHC. The point about access was compelling and there is one thing to focus on how well we are currently dialyzing the patients that we have but there is a cohort of patients who are not getting care, and from the Health Department standpoint is concerning and I am glad that this issue is being addressed.

Dr. Parson's also noted that she was heartened by the fact that many other healthcare systems have similar contracts for these services and that HHC is not a one off in this situation. With respect to the point brought up the increased turnover, as long as the quality of dialysis can be maintained, increased or faster turnover is actually to the benefit of the patient, many of these patients hate the fact that they had to spend hours three to four times a week in a dialysis center so getting them back to their otherwise productive life could be deemed beneficial. Dr. Parson's asked for clarification on the following two items: 1) tracking of metrics through Medicare data is obviously old and takes a bit of time to publish so she would be interested in learning more about how we would track the quality of care in a real time basis; and 2) while she appreciates the need for a contract to be longer than perhaps other contracts she inquired as to what would be our ability to step out of the contract if we were very dissatisfied with the quality of services

Dr. Wilson responded that it is possible to monitor the data with more recent data than the CMS data but not necessarily in real time as one must enter the data and then analyze it. The data will be reviewed and monitored locally by a panel that includes the medical directors of the dialysis sites. Plus it will be reviewed at the hospital level on a regular basis. It will also be collated and reviewed centrally as well and present to this Committee as other indicators such as the core measures are presented. So this Committee will be regularly informed of how the performance measures look. Mr. Russo stated that HHC has entered into other long term arrangements in which we have exercised ability to terminate the contract with a reasonable time, and, in a manner in which our patients are safely transitioned. Dr. Wilson noted that the contract has to be reasonable long to make it worthwhile for any vendor to make a capital investment in sites – some are shell spaces that need to be fully outfitted, obtain appropriate licenses, and there is significant lead time to ensure all is completed.

The resolution was moved for the full Board of Directors consideration.

INFORMATION ITEMS:

1. Patient Safety Update – FY 2012

Caroline M. Jacobs, MPH, MS.Ed., Senior Vice President, Safety & Human Development presented to the Committee. The targeted efforts in Fiscal Year 2012 included: 1) enterprise-wide strategic priorities in workforce development in TeamSTEPPS™ and The Just Culture and infection prevention and reduction; 2) medication safety; 3) assessment of staff perceptions of safety culture; 4) new Health and Human Services (HHS) Initiative - The Partnership for Patients; and 5) other activities.

The workforce development strategic priority has been to educate and train staff in the following two critical programs: 1) Just Culture for managers – 926 staff trained in FY 12 for a total of 8,539 since FY 11 and Simplified Just Culture – 3,588 staff trained in FY 12 for a total of 16,939 since FY 11; and 2) TeamSTEPPS Master Training – 104 staff trained in FY12 for a total of 724 since FY 11 and TeamSTEPPS training 3,802 staff trained in FY 12 for a total of 11,875 since FY 11.

The FY 12 strategic priorities around infection prevention and reduction were to: reduce the rate of healthcare acquired infections by 15% and a specific focus on central line associated blood stream infections (CLABSIs) and catheter associated urinary tract infections (CUTIs). The Division of Medical and Professional Affairs re-launched the "Journey to Zero" healthcare acquired infections campaign and tools such as TeamSTEPPS can be used to support HHC's "Journey to Zero" infections and other hospital acquired conditions and enable sustainment.

Lincoln Medical and Mental Health Center embedding TeamSTEPPS with clinical/programmatic work as demonstrated by the following achievements. Reduction in CAUTIs: 40% between 2009 – 2010; 80% between 2010 – 2011; and overall 98% between 2009 – 2011. Key elements to success included use of TeamSTEPPS tools and techniques including leadership, communication tools, situation awareness, and mutual support; and interdisciplinary support. Lincoln CAUTI rates in step down unit (# per 1,000 catheter days) decreased from 5.88 in the first quarter of 2009 to 2.4 in the second quarter of 2011, then to 0 in the fourth quarter of 2011. Lincoln's urinary catheter removed on post-op-day was 82% in the fourth quarter of 2009 compared to 100% in the fourth quarter of 2011. Metropolitan Hospital Center as a result of implementing TeamSTEPPS experienced a 71% reduction in physical altercations from six (6) per month in 2009 to 1.4 per month in 2011.

The enterprise-wide medication safety council focus includes: improving rate of medication reconciliation; improving anticoagulation therapy; and appropriate pain management and opioid use. For medication reconciliation the target is zero unreconciled medications. Percentage of unreconciled medications (per 100 medications) for the acute hospitals decreased from 10% in 2009 to 6.6% in 2011. The percentage in the long term care facilities decreased from 5.33% in 2009 to 2.9% in 2011.

Improving anticoagulation therapy: the number of patients receiving Heparin whose partial thromboplastin time (PTT) was appropriately managed and monitored increased positively from 84% in 2010 to 94% in 2011. The number of patients successfully recalled to clinic after not showing for an anticoagulation related follow-up visit increased positively from 88% in 2010 to 100% in 2011. Ms. Jacobs provided the Committee with a sample of the facilities anticoagulation therapy resource guides on intranet sites.

A Federal Mediation and Conciliation Services Grant supporting joint labor and management collaboration between HHC, CIR/SEIU, 1199 SEIU was obtained with the goal to improve medication safety, with a specific focus on opioids and pain management. These funds supported or will support the following: November 2011 Conference: *"Improving Medication Safety Through Effective Teamwork and Communication";* Six Medication Safety Grand Rounds for Interdisciplinary Teams at NCB/Jacobi, Harlem, Bellevue, Lincoln, Coney Island and Metropolitan to be completed by the end of September 2012; and the development of a best practice on opioids and pain management.

Ms. Jacobs demonstrated the pain management pocket guide that was developed which covers: types of pain; pain scale; assessment and types of severity of pain; evaluation of pain and treatment/management options; and recommended opioid and non-opioid medications and dosages.

The patient safety culture survey is based on the Agency for Healthcare Research and Quality (AHRQ) and includes: hospital survey on patient safety culture; medical office survey on patient safety culture specific to

our DTCs; and nursing home survey on patient safety culture. There are 42 – 52 questions per survey that roll up into 12 composites. Evidence-based tools are used to assess staff opinions about patient safety issues, medical errors and event reporting in their organization. The survey was available (electronically or hard copy) to all HHC employees, volunteers, and medical staff in all facility work areas from March 18th – April 4th. For the 2012 survey results, 23,415 responses enterprise-wide (61% response rate) was received. The analysis shows clear areas of strength and some opportunities for improvement based on the percentage positive responses to survey questions. Strengths are organizational learning – continuous improvement and management support for patient safety. Opportunities are non-punitive response to error and staffing. Ms. Jacobs provided the Committee with facility specific responses to the following four (4) survey questions: 1) we are actively doing things to improve patient safety; 2) mistakes have led to positive changes here; 3) staff worry that mistakes they make are kept in their personnel files; and 40 when a mistake is made but caught and corrected, how often is it reported?. The percentage of positive responses to frequency or events reported went from 57% in 2007 to 60% in 2010 and 63% in 2012.

The Federal initiative from the Health and Human Services (HHS) "Partnership for Patients" vision of improvement is achieving the Triple Aim = better health for populations; better health for individuals; and lower costs through improvement. The two following goals are to be achieved by December 2014: reduce hospital-acquired conditions in the aggregate by 40%; and reduce preventable readmissions in the aggregate by 20%. HHC has been selected to participate in the New York State Partnership For Patients (NYSPFP) Collaboration between GNYHA and HANYS. The aim is to work with hospitals to achieve CMS' goals by building the organizational capacity for rapid and sustainable improvement. Over 170 hospitals across NYS (including HHC) have joined the NYSPFP. HHC hospitals are participating on all 11 focus areas through the NYCPFP which are: adverse events; obstetrical adverse events; catheter-associated urinary tract infections; pressure ulcers; ventilator-associated pneumonia; central line associated blood stream infections; surgical site infections; preventable readmissions; injuries from falls and immobility; and venous thromboembolism.

Other patient safety activities that occurred during FY 12 included: patient and family engagement; the patient safety awareness week large scale event was the Patient Safety Jeopardy "Battle of the Networks" which Queens Hospital won & the Patient Safety Champions Awards celebration; large scale education and patient safety forums - *From Tears to Transparency: The Story of Michael Skolnik, TeamSTEPPS Master Trainer Update,* and *Advancing Patient Safety through Understanding Human Factors*; new curricula - *Connecting the Patient Safety Dots: Bridging TeamSTEPPS, The Just Culture, Disruptive Behavior, and Breakthrough;* and *Annual Review of TeamSTEPPS and Just Culture;* and collaborating on the revamp of the current root cause analysis process to a focus on harm reduction and learning.

2. MetroPlus Health Plan

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Highlights of the presentation follows.

MetroPlus Health Plan (Plan) has been licensed since 1985 in New York State as a Managed Care Organization. In 2001 the Plan converted from an HMO to a Prepaid Health Services Plan (PHSP) and became a wholly owned subsidiary corporation of the New York City Health and Hospitals Corporation (HHC). The Plan's lines of business include Medicaid Managed Care, Family Health Plus, Child Health Plus, Medicare plans, two Special Needs Plans (SNP) for the care of HIV+ members in Medicaid and Medicare, and MetroPlus Gold.

MetroPlus' mission is to provide its members with access to the highest quality, cost-effective health care including a comprehensive program of care management, health education and customer service. This is

accomplished by partnering with HHC and our dedicated providers. MetroPlus' vision is to provide access to the highest quality, cost-effective health care for our members, to achieve superior provider, member and employee satisfaction, and to be a fiscally responsible, ongoing financial asset to HHC. MetroPlus will strive to be the only managed health care partner that HHC will ever need. This will be accomplished by our fully engaged, highly motivated MetroPlus staff.

MetroPlus' values include: performance excellence - hold ourselves and our providers to the highest standards to ensure that our members receive quality care; fiscal responsibility - assure that the revenues we receive are used effectively; regulatory compliance - with all City, State and Federal laws, regulations and contracts; team work - everyone at MetroPlus will work together internally and with our providers to deliver the highest quality care and service to our members; accountability - to each other, our members and providers; and respectfulness - in the way that we treat everyone we encounter.

MetroPlus governance: the MetroPlus Board of Director's report up to the HHC Board of Directors. There are five (5) subcommittees of the MetroPlus Board of Directors: finance, audit and compliance, quality assurance, customer services and marketing which meet quarterly; and the executive committee which meets on an as needed basis. Dr. Saperstein also described the MetroPlus table of organization and the various departments within MetroPlus (Human Resources & Organizational Development; Strategic Planning; Chief Customer Officer; Chief Operating Officer; Chief Medical Director; Chief Financial Officer; and Internal Audits with a dotted line directly to the HHC Board of Directors).

As of June 29, 2012 the MetroPlus membership was 433,794. The below table compares membership numbers of June 1, 2011 and June 1, 2012. The primary areas of growth in the last year were in Medicaid, Family Health Plus, HIV SNP, Medicare, and MetroPlus Gold.

Line of Business	**# of Members**	
	June 1, 2011	June 1, 2012
Medicaid	346,665	365,907
Family Health Plus	34,396	36,800
Child Health Plus	18,927	16,349
Medicaid HIV SNP	5,230	5,809
Medicare	5,019	5,808
MetroPlus Gold	2,910	3,121

From a primary care perspective 54% of MetroPlus' members have a primary care doctor assigned at HHC; with 46% of those in the community. The goal of the community doctors, whenever possible, refer into HHC for inpatient and specialty care. In the last year, HHC has lost 2% of its primary care assignment to community providers.

MetroPlus Marketing staff is comprised of 150 facilitated enrollment (FE) representatives for Medicaid Managed Care, Child Health Plus (CHP), Family Health Plus (FHP). There are twenty-nine (29) enrollment

sales representatives for Medicare Advantage, and four (4) dedicated enrollment sales representatives (ESR's) for Managed Long Term Care marketing. MetroPlus marketing staff are located at HHC facilities, City agencies, CBO's, RVs, and Community Marketing sites. In 2011, 57,089 Access New York applications were submitted electronically to HRA, eliminating errors and increasing the efficiency of the Eligibility Department operations.

The Member Retention Department was created in 2006 in order to strategically retain the membership enrolled in MetroPlus' Medicaid (MA), Family Health Plus (FHP), Child Health Plus (CHP) and Medicare lines of business. Member Retention's Document Collection Unit assists with the completion of new enrollments. 2011 member retention performance is as follows: MA/FHP = 70%; CHP = 83%; and Medicare = 97% (average membership retained monthly).

MetroPlus' provider network has 14,977 providers as of June 29, 2012. The following table provides the breakdown per specialty.

Primary Care Providers (PCPs)	2,965
Specialty Providers	11,302
OB/GYN	710
TOTAL	14,977

HHC PCPs have declined while our membership has increased, contributing to our access issues.

	2Q10	2Q11	2Q12
HHC PCP sites	553	526	517

MetroPlus' relationship with HHC is excellent. We have a close collaboration with HHC at all levels of the clinical and administrative spectrum because we work together in: a forward-thinking environment; mutual population served: low-income, inner city communities, many racial minorities with higher health risk profiles; and mutual achievements. The continued growth of MetroPlus and its expansion into new lines of business will allow for the capture of new populations while assisting HHC in maintaining their patient and revenue base.

MetroPlus' financial arrangement with HHC is that: HHC assumes full risk for all members who select an HHC site; HHC assumes risk for all the medical care other than primary care when the member selects a community physician (that is part of the HHC Community Provider network) as their primary care provider; and MetroPlus assumes full risk for all members assigned to a primary care provider not affiliated with the HHC network and for all members in Medicaid HIV SNP and Medicare plans

The benefits of HHC risk arrangement are: allows for the alignment of incentives; improved outcomes and decreased utilization benefits both MetroPlus and HHC; an opportunity to maximize the percentage of plan revenue payable to HHC; and lessons learned from years of partnership will allow MetroPlus and HHC to successfully develop and operate an Accountable Care Organization (ACO) model of care.

Dr. Saperstein reviewed the administrative cost comparison for all plans for all lines of business – MetroPlus' weighted average total administrative cost is $19.79. Dr. Saperstein then revised the 2011 budget. He highlighted that MetroPlus' total estimated revenue for 2011 is $1.4 billion and their administrative expense authority is $113 million which is a reflection of their low per member per month administrative costs. Prediction for 2012, revenue will hit $2 billion as a result of new NYS programs being carved in to them.

The following table outlines the 2012 NYS DOH Medicaid Quality Incentive Bonus. MetroPlus' preliminary results using last year's rates are 63.52 points.

# of Measures Under 50th Percentile	# of Measures Between 50th and 74th Percentile	# of Measures Between 75th and 89th Percentile	# of Measures Meeting or Exceeding 90th Percentile
5	6	5	10

The five (5) QARR measures in which MetroPlus were under the 50th percentile are: antidepressant medication-acute phase; diabetes BP 140/90; seven day follow-up after a mental health hospitalization; follow-up care for children prescribed ADHD medication-initiation phase; and spirometry testing for COPD. MetroPlus will be in receipt of their scores for the QARR portion of the incentive in the Fall of 2012.

Based on the Consumer's Guide to Medicaid Managed Care in NYC, MetroPlus has been rated #1 Medicaid Managed Care health plan in NYC for six out of the last seven years. Based on indicators chosen by the New York State Department of Health (NYSDOH) and published in the Consumer's Guide to Medicaid Managed Care in New York City. The 2011 guide, based in part on quality ratings submitted by the health plans and a NYSDOH member satisfaction survey, shows MetroPlus with an 82% percent overall rating, ranking it first among New York City's eleven Medicaid Managed Care plans. The ratings are based on measures including plans' preventive and well-care for adults and children, quality of care provided to members with illnesses and patient satisfaction with access and service. For the first time ever, in 2011 MetroPlus was ranked #1 in New York State and New York City.

Dr. Saperstein moved on to the discussion of clinical risk groups (CRGs) which is a risk based methodology in which a plan obtains money based on how sick its members are. NYS uses 3M's clinical risk groups (CRG) software to determine the disease classification of Medicaid and FHP plan members and uses those scores to risk adjust health plan premiums. CRGs are assigned using one in-patient claim or at least two outpatient visits per calendar year, otherwise the member is considered healthy - significant co-morbidities and severity greatly influence CRG assignment and lack of complete coding affects the member's CRG score. MetroPlus Network Relations and Quality Management Departments share facility-based information throughout the year with HHC senior leadership and Managed Care, as well as community providers, on: members who have not had a PCP visit (non-users); and members who have not had appropriate tests/follow-up (QARR measures). MetroPlus works with HHC and other providers to get members into care, improving their medical outcomes; and MetroPlus encourages providers to appropriately code all encounters; this has a significant effect on the rates they receive. The ultimate goal is that if a patient has secondary diagnoses and you are thinking about them during the actual care, they should be coded appropriately. 2010 CRG scores will be used for NYS FY 2012-2013 risk adjusted premium rates. MetroPlus' FHP index score declined 0.1% from '09-10 and the Medicaid index score was unchanged.

Utilization Management Initiatives (2011 key achievements) to promote appropriate utilization of MetroPlus' risk arrangement with HHC include: Chest Pain Focused Review – 2011 net denial rate was 30% with a $1,064,250 savings; physical occupational/speech therapy review – 2011 net denial rate of 27% with a $562,664 savings; and DRG validation – pre-payment savings of $8.4 million with a post-payment of $2.8 million total claims recovery. Medicare SNP model of care implementation received maximum three (3) year approval on Model of Care with a score of 88.75%. Medicare SNP structure and process measures scored 100% in 2011.

In 2011, 36% of denials were appealed. Excluding lack of clinical denials, 63% of MetroPlus denials were upheld. The 2012 Case Management key initiatives are: 1) reduction of readmissions – outreach to all Medicaid members within 48 hours of a hospital admission; and 20 enhanced facility relationships - each HHC facility has a dedicated MetroPlus case manager for assistance with care coordination.

MetroPlus processed approximately 4.7 million claims in 2011. Overall, the average non-Medicare claims processing time from receipt to payment for January through December 2011 was 8.4 days. The Claims Department processed to finalization 99.2% of these receipts within the 30-day timeframe and 99.5% within the 45 day timeframe as set out under the State Insurance Department Prompt Pay Law.

Dr. Saperstein highlighted the numerous audits that MetroPlus has undergone as follows: 1) Article 44 Regulatory Audit - no findings; SDOH required simplification of language used in denial letters; 2) Child Health Plus Audit - successfully completed on the first round; 3) Medicare SNP Model of Care Implementation - CMS Special Needs Plan application: 88% score in 2011; MetroPlus now has a 3-year exemption to the annual submission requirement, and NCQA Structure and Process Measures: 100% score in last audit – 2011; and 4) Finance Audits: successfully completed 2011 Certified Financial Statements, 2008 Medicare Financial Audit and 2011 Medicare Bid Audit - no audit found any material weakness; incorporating suggestions from Bid Audit to enhance future bid submissions.

The Network Relations Department was formed in 2005 to improve and expand the level of communication between MetroPlus and its participating facilities, members and providers. Network Relations Managers meet regularly with top level administrators at network facilities and Community Providers to discuss quality indicators, CRGs and member/patient satisfaction. Provider Services Representatives work with Participating Providers to ensure that they provide the highest level of care to our members: 2,141 encounters in first quarter of 2012. Customer Services Representatives are located at HHC facilities and handle member complaints and inquiries: 37,966 inquiries in first quarter of 2012.Care Coordinators conduct member outreach, education and case management: 3,479 outreaches in first quarter of 2012. The Network Relations Department continues to increase alignment between HHC and MetroPlus by coordinating meetings with Senior Executive leadership to discuss each facility's key performance.

MetroPlus' customer services' call center operates six days a week (Monday – Saturday), 12 hours a day (8 AM – 8 PM). Over the past 12 months (June 2011 - May 2012), the Call Center received a total of 975,635 calls. Customer Services Representatives are thoroughly trained to handle calls from members and providers for all lines of business. Call types range from basic plan eligibility, benefit/services, assisting with appointments/referrals, address/demographic changes, selection of PCP, assistance with the homeless population, arranging transportation, provider/claims inquiries, DME and Pharmacy issues, complaint investigations and Utilization Management calls which include referrals to case management, authorization, and Managed Long Term Care.

Customer Services Representatives (CSR) speak approximately 15 languages. In addition to handling inbound calls, each CSR is assigned to a project team that is responsible for conducting outbound calls to members. These outbound calls cover three different areas: 1) new member orientations; 2) completion of

health risk assessment forms (HRA) for submission to case management team; and 3) member notifications including PCP relocations, PCP terminations, and auto-assignments.

Information is key to MetroPlus' current and future success. MetroPlus' IT infrastructure has grown proportionally with Plan growth. Eighty percent (80%) of applications systems are in regular use, run on over 135 servers, 25% of MetroPlus servers are physical and 75% are virtual, 20 servers are dedicated to support telephone applications, and MetroPlus is moving to 100% virtual servers. Server configuration is duplicated and running at MetroPlus' BRP site, SunGard®, for critical systems.

The original contract with DST Health Solutions – PowerStepp System was entered into in 2000. The contract was renewed in 2007 which ends in 2015. A negotiated acquisition process was underway in 2011, and it was decided that MetroPlus did not have the necessary resources or infrastructure to proceed with replacing the current core system. MetroPlus will evaluate their core system again in 2012, beginning with a phase one system review.

Major benefits that are delegated to third parties include dental services to HealthPlex and pharmacy benefit management (PBM) to CVS/Caremark. On an annual basis, MetroPlus conducts an operational audit of these vendors to assess operational performance as well as compliance with State and CMS regulations. In 2011, MetroPlus conducted these audits via desk review; in 2012, the audits will perform onsite operational audits. The performance reports and any other issues identified with a vendor are reported on a quarterly basis to the MetroPlus Quality Assurance Committee.

MetroPlus has fully transitioned to a new Pharmacy Benefit Manager (PBM), CVS Caremark, selected through the RFP process. Effective October 1, 2011, MetroPlus, in conjunction with CVS Caremark, took over responsibility for managing pharmacy benefits to an additional 388,000 Medicaid and Family Health Plus members (~$400M annually), which were managed by Fee for Service Medicaid. MetroPlus' Child Health Plus, Medicare Advantage and MetroPlus Gold members were also transitioned to CVS Caremark on January 1, 2012. The MetroPlus team has worked very closely with CVS Caremark to ensure a smooth transition and implementation for all of MetroPlus members and providers.

Effective August 1, 2011, personal care services (PCS) will be carved into the MetroPlus benefit package to provide services essential to the maintenance of the member's health and safety in the home, and for assistance with personal hygiene, dressing, feeding, nutritional and environmental support functions. MetroPlus is providing personal care services to approximately 1,210 members. This provision required MMC/FHP plans to contract with a Certified Home Health Agency (CHHA) to conduct assessments and a network of personal care agencies. HHC and NYCHSRO provide nursing assessments.

Statewide, there are approximately 12,000 restricted recipients and seventy-five percent (75%) reside in NYC. Mandatory enrollment into managed care began July 2011. MetroPlus is managing restrictions for 1,025 restricted recipients. MetroPlus has maintained current restrictions as set by the SDOH and continually assesses members to determine if the restriction should remain in place.

Mandatory enrollment began in New York City in July 2012 for persons 21 and older in need of 120 days or more of service into a Managed Long Term Care (MLTC) or other "coordinated care" model. Certain exclusions/exemptions apply (e.g. hospice, Native Americans) and assessments are required every six months. Enrollees will be given 30 days to select an MLTC plan. After 30 days, enrollees will be auto-assigned to a partial cap MLTC plan and it is unclear if the State will auto-assign members to plans with a newly awarded license. MetroPlus has submitted an application to become a MLTC and expects to be awarded a license after a July 2012 readiness review.

The challenges that MetroPlus faces are: 1) Dental carve-in affects approximately 350,000 members - change from FFS to HealthPlex; 2) Health care reform - NYS Exchange must ensure MetroPlus' ability to participate; 3) Medicare membership growth - 11,000 members by June 30, 2013; 4) Multiple CMS audits; 5) MLTC implementation; 6) Behavioral health integration; and 7) ACO implementation with HHC.

In summary, MetroPlus has many growth opportunities and challenges and they look forward to working with HHC and sharing their progress.

There being no further business the meeting adjourned at 11:47 A.M.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
September 20th, 2012

Total plan enrollment as of August 31st, 2012 was 436,735. Breakdown of plan enrollment by line of business is as follows:

Medicaid	368,883
Child Health Plus	16,102
Family Health Plus	36,886
MetroPlus Gold	3,157
Partnership in Care (HIV/SNP)	5,810
Medicare	5,897

This month, we added 921 members. Our largest growth was in our Medicaid line of business. MetroPlus added 92 new enrollees in Medicare.

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

In the month of August, we lost 1,128 members to Fidelis Care and 1,101 members to Health First. After more research, it appears that the MetroPlus dental transition to Healthplex in July may have contributed to this loss.

The 2013 Medicare Bids were submitted to CMS in June and accepted in August. Due to rate cuts and very high drug costs, significant changes had to be made to the Partnership in Care Plan (HMO SNP) for 2013. Monthly premiums increased from $0 to $23.70, copayments were increased and several benefits had to be cut from the package including hearing aids, transportation services, and vision services.

On September 1, 2012 the NYS 599 statute for Medicaid MCO's and FHP Plans' will commence requiring reimbursement to mental health clinics for services under the ambulatory patient group (APG) rate setting methodology. One challenge is that the 3M grouper for this change has not yet been released. The state has informed providers to hold their claims until the grouper is released. NYS will then only allow plans 2-3 days after the release to update their systems. An adjustment to premium rates for Mental Health APGs will be included in a July 2012 rate package and will be pro-rated for the implementation date. NYS indicated the impact for NYC is expected to be approximately $33,000,000.

The Affordable Care Act (ACA) included a provision to expand primary care access and address physician shortages through an increase to primary care physician Medicaid reimbursement to of 100% RBRVS - Effective January of 2013. Eligible providers are those recognized by the American Board of Medical Specialties as: Family Medicine, General Internal Medicine, Pediatric Medicine, and recognized Sub-specialties.

MetroPlus continues to work very closely with HHC towards the successful implementation of the HHC Health Home. Membership outreach commenced on July 16th, 2012. MetroPlus sent the initial mailing to eligible members and has routed care management calls to HHC for handling. The Health Home contract has been executed between MetroPlus and HHC. Enrollment is very slow so far. There are only 15 MetroPlus members in the HHC Health Home.

Mandatory enrollment for Managed Long Term Care (MLTC) began on July 2nd, 2012. The MetroPlus application for a MLTC License was completed, submitted and approved. MetroPlus has been granted a Provider ID. We have started testing our systems with the NYS enrollment broker, Maximus as of August 24th, 2012. We are still waiting for our formal contract and license.

In 2011, NYS approved a mandate for coverage of autism services. This legislation will now be enacted and is effective November 1st, 2012. The Mandate applies to all policies and contracts issued, or renewed, modified, altered or amended on or after November 1st, 2012 and will affect approximately 14,000 MetroPlus Child Health Plus members. Every policy that includes coverage of physician services, medical, major medical or similar comprehensive-type coverage must provide coverage for autism screening, diagnosis, and treatment. There are no age limits or limits to visits that are solely applied to the treatment of autism spectrum disorder. Coverage is subject to a maximum benefit of $45,000 per year per covered individual.

Medicaid Redesign Team Managed Care Benefit and Population Expansion changes continue to occur as we move to the end of 2012.

Effective October 1st, 2012, Consumer Directed Personal Care (CDPAP) will be carved into the MetroPlus benefit package. CDPAP provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living or skilled nursing services. Services can include any of the services provided by a personal care aide, home health aide, or nurse. Recipients have flexibility and freedom in choosing their caregivers. The consumer or the person acting on the consumer's behalf (such as the parent of a disabled or chronically ill child) assumes full responsibility for hiring, training, supervising, and – if necessary– terminating the employment of persons providing the services. MetroPlus is in the process of securing a fiscal intermediary to provide paperwork facilitation, payroll, and benefits administration for this benefit.

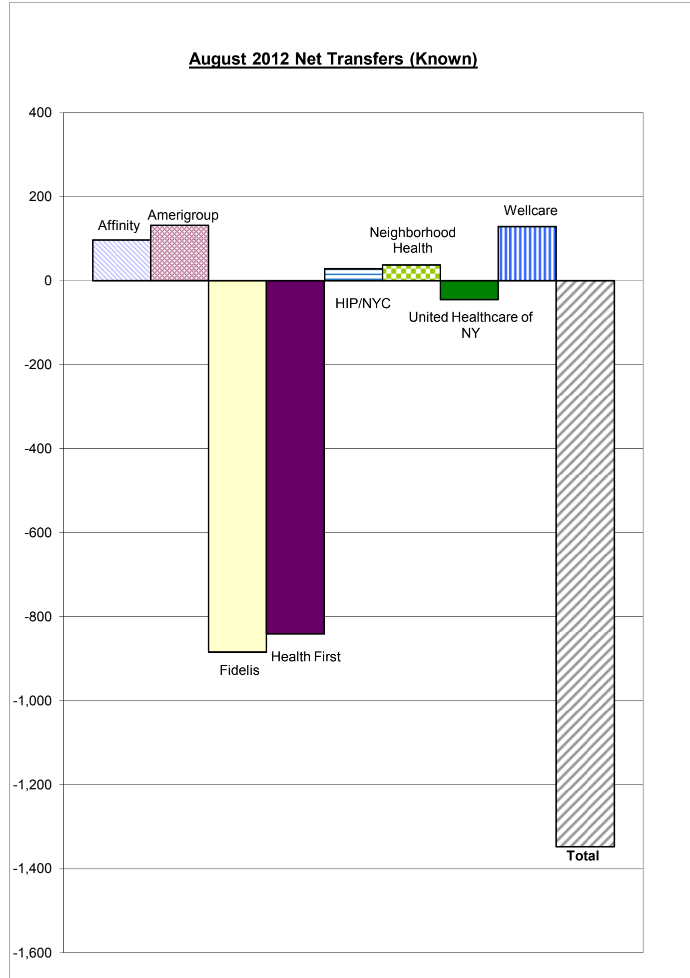
Finally, effective January 1st 2013, New York State will transition the management of all non-emergency medical transportation services for enrollees in a managed care plan to LogistiCare, a regional transportation company. For the last 6 months, all Medicaid fee-for-service enrollees have been using this provider.

Disenrollments TO Other Plans		Aug-12			Sep-11 to Aug-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	1	1	0	1	1
	VOL.	14	111	125	154	1,322	1,476
Affinity Health Plan	TOTAL	14	112	126	154	1,323	1,477
	INVOL.	0	0	0	3	26	29
	VOL.	18	241	259	247	2,612	2,859
Amerigroup/Health Plus/CarePlus	TOTAL	18	241	259	250	2,638	2,888
	INVOL.	0	2	2	1	12	13
	VOL.	142	984	1,126	466	3,836	4,302
Fidelis Care	TOTAL	142	986	1,128	467	3,848	4,315
	INVOL.	0	4	4	3	21	24
	VOL.	110	991	1,101	599	6,621	7,220
Health First	TOTAL	110	995	1,105	602	6,643	7,245
	INVOL.	0	0	0	0	2	2
	VOL.	7	84	91	130	1,009	1,139
HIP/NYC	TOTAL	7	84	91	131	1,011	1,142
	INVOL.	0	1	1	0	8	8
	VOL.	23	140	163	149	1,398	1,547
Neighborhood Health	TOTAL	23	141	164	149	1,407	1,556
	INVOL.	0	0	0	0	8	8
	VOL.	18	129	147	142	983	1,125
United Healthcare of NY	TOTAL	18	129	147	142	991	1,133
	INVOL.	0	0	0	2	9	11
	VOL.	2	38	40	27	264	291
Wellcare of NY	TOTAL	2	38	40	29	273	302
	INVOL.	0	8	8	9	87	96
	VOL.	334	2,718	3,052	1,914	18,045	19,959
Disenrolled Plan Transfers:	TOTAL	334	2,726	3,060	1,924	18,134	20,058
	INVOL.	2	30	32	58	490	548
	VOL.	21	101	122	180	906	1,086
Disenrolled Unknown Plan Transfers:	TOTAL	23	131	154	239	1,398	1,637
	INVOL.	1,216	10,338	11,554	13,338	120,671	134,009
	UNK.	5	1	6	27	85	112
	VOL.	0	46	46	345	1,909	2,254
Non-Transfer Disenroll Total:	TOTAL	1,221	10,385	11,606	13,710	122,665	136,375
	INVOL.	1,218	10,376	11,594	13,405	121,248	134,653
	UNK.	5	1	6	29	89	118
	VOL.	355	2,865	3,220	2,439	20,860	23,299
Total MetroPlus Disenrollment:	**TOTAL**	**1,578**	**13,242**	**14,820**	**15,873**	**142,197**	**158,070**

Disenrollments FROM Other Plans	Aug-12			Sep-11 to Aug-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	23	200	223	266	2,570	2,836
Amerigroup/Health Plus/CarePlus	47	344	391	662	5,421	6,083
Fidelis Care	22	222	244	206	2,413	2,619
Health First	20	244	264	222	2,484	2,706
HIP/NYC	7	112	119	92	1,317	1,409
Neighborhood Health	16	185	201	271	2,156	2,427
United Healthcare of NY	6	96	102	114	1,283	1,397
Wellcare of NY	32	137	169	253	1,596	1,849
Total	173	1,540	1,713	2,086	19,240	21,326
Unknown (not in total)	2,029	13,337	15,366	24,891	141,833	166,724

Data Source: RDS Report 1268a&c Updated 08/23/2012

Net Difference	Aug-12			Sep-11 to Aug-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	9	88	97	112	1,247	1,359
Amerigroup/Health Plus/CarePlus	29	103	132	412	2,783	3,195
Fidelis Care	-120	-764	-884	-261	-1,435	-1,696
Health First	-90	-751	-841	-380	-4,159	-4,539
HIP/NYC	0	28	28	-39	306	267
Neighborhood Health	-7	44	37	122	749	871
United Healthcare of NY	-12	-33	-45	-28	292	264
Wellcare of NY	30	99	129	224	1,323	1,547
Total	-161	-1,186	-1,347	162	1,106	1,268



New Member Transfer From Other Plans

	2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	16	194	20	174	23	203	17	189	13	207	19	191	20	254	30	242	38	296	26	240	21	180	23	200	2,836
Amerigroup/Health Plus/CarePlus	58	451	61	388	60	428	40	422	39	445	43	348	55	560	63	494	77	614	74	554	45	373	47	344	6,083
Fidelis Care	19	233	24	173	19	232	18	216	17	183	10	171	16	209	17	190	27	225	11	200	6	159	22	222	2,619
Health First	25	146	14	184	26	214	13	198	22	164	8	188	17	250	20	214	19	254	25	214	13	214	20	244	2,706
HIP/NYC	10	117	6	94	7	102	5	104	11	97	8	89	10	128	7	118	5	130	7	130	9	96	7	112	1,409
Neighborhood Health Provider PHPS	25	139	26	149	24	169	29	125	16	205	18	166	18	234	22	191	30	252	32	201	15	140	16	185	2,427
United Healthcare of NY	10	82	6	72	8	101	10	121	8	101	14	90	10	126	10	90	11	163	11	145	10	96	6	96	1,397
Unknown PLan	2,022	9,715	1,927	9,395	2,189	12,792	1,822	11,462	2,162	11,746	2,154	13,040	2,066	11,409	1,914	10,652	2,476	14,766	2,180	12,009	1,950	11,510	2,029	13,337	166,724
Wellcare of NY	11	125	20	146	27	142	15	125	19	138	14	99	31	122	23	146	15	185	27	147	19	84	32	137	1,849
TOTAL	2,196	11,202	2,104	10,775	2,383	14,383	1,969	12,962	2,307	13,286	2,288	14,382	2,243	13,292	2,106	12,337	2,698	16,885	2,393	13,840	2,088	12,852	2,202	14,877	188,050

Report ID: MHP1268C
Report Run Date: 8/24/2012

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2012

Other Plan Name	Category	2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	VOLUNTARY	13	98	10	136	21	124	19	99	10	108	15	90	6	71	7	130	14	128	13	115	12	112	14	111	1,476
	TOTAL	13	98	10	136	21	124	19	99	10	108	15	90	6	71	7	130	14	128	13	115	12	112	14	112	1,477
Amerigroup/Health Plus/CarePlus	INVOLUNTARY	0	0	0	0	2	9	0	1	0	2	0	1	0	2	0	3	0	2	1	5	0	1	0	0	29
	VOLUNTARY	21	219	22	169	29	259	28	230	11	203	17	266	14	128	20	198	33	189	23	267	11	243	18	241	2,859
	TOTAL	21	219	22	169	31	268	28	231	11	205	17	267	14	130	20	201	33	191	24	272	11	244	18	241	2,888
Fidelis Care	INVOLUNTARY	0	0	1	1	0	1	0	0	0	1	0	2	0	0	0	1	0	1	0	1	0	2	0	2	13
	VOLUNTARY	20	176	22	203	27	258	27	233	25	222	33	267	17	148	22	266	28	275	27	239	76	565	142	984	4,302
	TOTAL	20	176	23	204	27	259	27	233	25	223	33	269	17	148	22	267	28	276	27	240	76	567	142	986	4,315
Health First	INVOLUNTARY	0	0	0	1	0	2	0	0	1	5	0	1	1	0	1	3	0	1	0	2	0	2	0	4	24
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	VOLUNTARY	34	412	40	406	42	488	39	461	26	516	43	549	29	299	53	478	62	635	44	602	77	784	110	991	7,220
	TOTAL	34	412	40	407	42	490	39	461	27	521	43	550	30	299	54	481	62	636	44	604	77	787	110	995	7,245
HIP/NYC	INVOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	2
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	7	90	11	55	12	78	11	87	10	92	9	91	9	54	15	112	14	99	15	83	10	84	7	84	1,139
	TOTAL	7	90	11	55	12	78	11	87	10	92	10	92	9	54	15	113	14	99	15	83	10	84	7	84	1,142
Neighborhood Health Provider PHPS	INVOLUNTARY	0	0	0	0	0	2	0	1	0	2	0	1	0	0	0	1	0	0	0	0	0	0	0	1	8
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	8	120	6	113	15	144	14	131	15	96	11	122	7	75	14	94	12	138	17	106	7	119	23	140	1,547

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2012

		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood :	TOTAL	8	120	6	113	15	146	14	132	15	98	11	123	7	76	14	95	12	138	17	106	7	119	23	141	1,556
United Healthcare of NY	INVOLUNTARY	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	0	3	0	1	0	0	8
	VOLUNTARY	10	72	7	48	18	111	16	74	14	70	8	81	7	49	8	68	12	103	11	69	13	109	18	129	1,125
	TOTAL	10	72	7	48	18	112	16	74	14	71	8	81	7	50	8	69	12	103	11	72	13	110	18	129	1,133
Wellcare of NY	INVOLUNTARY	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2	5	0	0	0	2	0	0	11
	VOLUNTARY	3	22	8	18	0	9	2	29	0	20	2	26	2	13	1	17	3	27	0	30	4	15	2	38	291
	TOTAL	3	22	8	18	0	9	2	29	0	21	2	26	2	13	1	18	5	32	0	30	4	17	2	38	302
Disenrolled Plan Transfers	INVOLUNTARY	0	0	1	2	2	15	0	2	1	12	0	6	1	3	1	11	2	9	1	11	0	8	0	8	96
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	0	0	3
	VOLUNTARY	116	1,209	126	1,148	164	1,471	156	1,344	111	1,327	138	1,492	91	837	140	1,363	178	1,594	150	1,511	210	2,031	334	2,718	19,959
	TOTAL	116	1,209	127	1,150	166	1,486	156	1,346	112	1,339	139	1,498	92	841	141	1,374	180	1,603	151	1,522	210	2,040	334	2,726	20,058
Disenrolled Unknown Plan Transfers	INVOLUNTARY	3	35	7	53	5	36	3	27	3	43	3	35	6	31	7	84	6	52	3	33	10	31	2	30	548
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	5	62	5	55	21	94	17	116	9	52	7	79	19	68	26	73	6	37	34	104	10	65	21	101	1,086
	TOTAL	8	97	12	108	26	130	20	143	12	95	11	115	25	100	33	157	12	89	37	137	20	96	23	131	1,637
Non-Transfer Disenroll Total	INVOLUNTARY	1,112	10,295	1,011	9,917	1,023	9,743	1,155	10,165	1,161	10,307	1,019	10,238	1,252	10,186	1,063	9,781	1,079	9,297	1,273	10,943	974	9,461	1,216	10,338	134,009
	UNKNOWN	1	3	1	3	1	5	1	6	1	5	1	14	2	13	2	15	3	7	4	5	5	8	5	1	112
	VOLUNTARY	0	52	1	55	252	386	2	60	2	82	1	63	78	781	2	96	7	132	0	90	0	66	0	46	2,254
	TOTAL	1,113	10,350	1,013	9,975	1,276	10,134	1,158	10,231	1,164	10,394	1,021	10,315	1,332	10,980	1,067	9,892	1,089	9,436	1,277	11,038	979	9,535	1,221	10,385	136,375
Total MetroPl	INVOLUNTARY	1,115	10,330	1,019	9,972	1,030	9,794	1,158	10,194	1,165	10,362	1,022	10,279	1,259	10,220	1,071	9,876	1,087	9,358	1,277	10,987	984	9,500	1,218	10,376	134,653

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2012

		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	UNKNOWN	1	3	1	3	1	5	1	6	1	5	3	15	2	15	2	15	3	7	4	5	5	9	5	1	118
	VOLUNTARY	121	1,323	132	1,258	437	1,951	175	1,520	122	1,461	146	1,634	188	1,686	168	1,532	191	1,763	184	1,705	220	2,162	355	2,865	23,299
	TOTAL	1,237	11,656	1,152	11,233	1,468	11,750	1,334	11,720	1,288	11,828	1,171	11,928	1,449	11,921	1,241	11,423	1,281	11,128	1,465	12,697	1,209	11,671	1,578	13,242	158,070

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
August-2012

		Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
Total Members	Prior Month	424,449	427,025	428,172	428,780	434,704	435,814	436,735
	New Member	18,478	17,428	16,375	21,448	18,210	16,523	17,684
	Voluntary Disenroll	1,991	2,031	1,884	2,137	2,051	2,578	3,417
	Involuntary Disenroll	13,911	14,250	13,883	13,387	15,049	13,024	14,230
	Adjusted	23	14	31	-20	591	1,732	0
	Net Change	2,576	1,147	608	5,924	1,110	921	37
	Current Month	427,025	428,172	428,780	434,704	435,814	436,735	436,772
Medicaid	Prior Month	355,999	358,459	359,909	360,899	366,614	367,879	368,883
	New Member	15,369	14,309	13,357	17,824	14,947	13,541	14,791
	Voluntary Disenroll	1,634	1,686	1,532	1,763	1,705	2,163	2,865
	Involuntary Disenroll	11,275	11,173	10,835	10,346	11,977	10,374	11,278
	Adjusted	-41	-51	-37	-77	541	1,630	0
	Net Change	2,460	1,450	990	5,715	1,265	1,004	648
	Current Month	358,459	359,909	360,899	366,614	367,879	368,883	369,531
Child Health Plus	Prior Month	18,209	17,803	17,521	17,132	16,705	16,349	16,102
	New Member	433	526	514	503	421	452	396
	Voluntary Disenroll	36	29	28	24	22	37	54
	Involuntary Disenroll	803	779	875	906	755	662	732
	Adjusted	65	65	66	61	58	34	0
	Net Change	-406	-282	-389	-427	-356	-247	-390
	Current Month	17,803	17,521	17,132	16,705	16,349	16,102	15,712
Family Health Plus	Prior Month	35,860	36,274	36,209	36,296	36,813	36,822	36,886
	New Member	2,258	2,232	2,094	2,668	2,354	2,076	2,166
	Voluntary Disenroll	146	188	168	191	184	220	355
	Involuntary Disenroll	1,698	2,109	1,839	1,960	2,161	1,792	2,044
	Adjusted	-3	-3	-1	-7	-8	13	0
	Net Change	414	-65	87	517	9	64	-233
	Current Month	36,274	36,209	36,296	36,813	36,822	36,886	36,653

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
August-2012

		Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
HHC	Prior Month	3,094	3,123	3,110	3,128	3,133	3,135	3,157
	New Member	42	31	33	26	14	49	1
	Voluntary Disenroll	0	0	0	1	0	0	0
	Involuntary Disenroll	13	44	15	20	12	27	62
	Adjusted	3	3	4	7	5	53	0
	Net Change	29	-13	18	5	2	22	-61
	Current Month	3,123	3,110	3,128	3,133	3,135	3,157	3,096
SNP	Prior Month	5,664	5,720	5,723	5,743	5,789	5,824	5,810
	New Member	190	135	133	179	179	132	105
	Voluntary Disenroll	41	28	42	44	37	48	37
	Involuntary Disenroll	93	104	71	89	107	98	71
	Adjusted	-1	0	0	-2	-3	4	0
	Net Change	56	3	20	46	35	-14	-3
	Current Month	5,720	5,723	5,743	5,789	5,824	5,810	5,807
Medicare	Prior Month	5,623	5,646	5,700	5,582	5,650	5,805	5,897
	New Member	186	195	244	248	295	273	225
	Voluntary Disenroll	134	100	114	114	103	110	106
	Involuntary Disenroll	29	41	248	66	37	71	43
	Adjusted	0	0	-1	-2	-2	-2	0
	Net Change	23	54	-118	68	155	92	76
	Current Month	5,646	5,700	5,582	5,650	5,805	5,897	5,973

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a contract with Epic Systems Corporation for an Enterprise-wide Electronic Medical Record (EMR) System including the software license, installation, training and maintenance to be used throughout the Corporation's facilities. The contract will be for an initial term of ten years, with an additional five-year renewal option, exercisable solely by the Corporation, in an amount not to exceed $302,807,986.

WHEREAS, the Corporation desires to implement a completely integrated Electronic Medical Record system with the intent to centralize the clinical functions currently available in eight electronic instances across the Corporation's health care facilities; and

WHEREAS, a qualified EMR vendor is required to assist the Corporation to design, develop and implement an Integrated Clinical Information System that will allow the Corporation's health care providers to use a single database within a single data repository and help transform the delivery of safe, efficient, and effective care; and

WHEREAS, the Corporation performed an assessment of available market options, leading to the issuance of a Negotiated Acquisition that was released July 16, 2008 in accordance with the Corporation's operating procedures; and

WHEREAS, a selection committee composed of the Corporation's Central Office and facility representatives considered proposals from nine EMR vendors and recommended that the Corporation enter into a contract with Epic Systems Corporation; and

WHEREAS, the overall responsibility for the monitoring of the contract will be under the direction of the Senior Vice President/Corporate Chief Information Officer;

NOW THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a contract with Epic Systems Corporation for an Enterprise-wide Electronic Medical Record System including the software license, installation, training and maintenance to be used throughout the Corporation's facilities. The contract will be for an initial term of ten years, with an additional five-year renewal option, exercisable solely by the Corporation, in an amount not to exceed $302,807,986.

EXECUTIVE SUMMARY

EPIC SYSTEMS CORPORATION
ELECTRONIC MEDICAL RECORD

The accompanying resolution requests approval to enter into a ten year contract with an additional five year renewal option with Epic Systems Corporation to provide the Integrated Clinical Information System (ICIS) Electronic Medical Record (EMR) for the New York City Health and Hospitals Corporation for a total amount, inclusive of $22,971,500 for training and implementation, not to exceed $302,807,986.

The existing EMR used at HHC is a legacy system, which, over several years, continues to lose market share. The product has had four changes in ownership (HDS, Medaphis, Per Se, Misys, and now QuadraMed). In 2006, HHC reviewed the status of our current EMR in the marketplace. It found there was significant executive turnover including at the CEO level, minimal new client sales during the previous two years, a relatively small budget for research and development, and that other products have surpassed the incumbents' medical record functionality. The product (QCPR) and current vendor were determined to be unable to support HHC's future need for the next generation EMR.

The Corporation has selected EPIC, a single enterprise-wide EMR to meet the needs of HHC's expansive size, improve patient care, control costs, and overcome gaps in care transitions. In order to fully realize the benefits provided by the new ICIS system, HHC will undergo an intensive clinical standardization process which, together with the new technology, will position HHC for the challenges of an increasingly complex healthcare marketplace.

HHC wishes to procure the EPIC solution to be able to increase patient safety through the use of efficient and effective decision support. The EPIC system is scalable to the size and performance requirements of HHC and able to meet the unique requirements and workflows of facilities and programs throughout HHC. The EPIC System conforms to emerging and evolving HIT standards and utilizes modern technology to allow for interoperability with external systems, RHIO's and other providers.

The EPIC EMR will be implemented at all eleven (11) HHC acute care hospitals, five (5) long term care/long-term acute care hospital locations, six (6) diagnostic and treatment centers and over seventy (70) other community based clinics. More than 8,000 physicians, 2,500 residents, 9,000 nurses, and many other clinical professionals will directly interact with the ICIS system on a daily basis and nearly all 39,000 of HHC's dedicated employees will be impacted by the new clinical system. The solution will be implemented within a scalable highly-available environment with full disaster recovery capabilities to minimize downtime.

In 2008 HHC planned and initiated a Negotiated Acquisition for the new EMR. The following year, the Federal Government announced Meaningful Use incentive funding and HHC is currently attesting to meaningful use with an estimated $125,000,000 of incentive payments for the hospital program. These funds will be utilized to support the implementation costs for this software.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: THE INTEGRATED CLINICAL INFORMATION SYSTEMS-EMR PROJECT

Project Title & Number: THE INTEGRATED CLINICAL INFORMATION SYSTEMS-EMR PROJECT

Project Location: HHC – Enterprise Wide

Requesting Dept.: CLINICAL INFORMATION SYSTEMS

Successful Respondent: EPIC SYSTEMS CORPORATION

Contract Amount: **$ 302,807,986**

Contract Term: TEN YEARS WITH ONE 5 YEAR OPTION TO RENEW

Number of Respondents: NINE
(If Sole Source, explain in Background section)

Range of Proposals: $ 282,425,568 to $ 389,224,964

Minority Business Enterprise Invited: No If no, please explain: Solicitation was publicly advertised

Funding Source:
General Care X
Capital X
Grant: explain
Other: explain Meaningful Use Incentive Funding, Capital Request

Method of Payment:
Lump Sum
Per Diem
Time and Rate
Other: explain Payments will be lump sum with subsequent scheduled monthly payments in addition to payments based on milestones and time and materials for services.

EEO Analysis: Approved as of 5/10/2012

Compliance with HHC's McBride Principles? X Yes No

Vendex Clearance X Yes No

Background *(include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):*

HHC is dependent upon robust clinical information systems to enable it to achieve and maintain excellence in patient care. The Current EMR vendor, QuadraMed is losing resources and market share. Several key programmers have left the organization and the software upgrades have been challenging. HHC needed to perform 24 upgrades over 18 months, just to reach stage I of meaningful use. These upgrades consumed a tremendous amount of staff time and resulted in several significant periods when entire hospital networks were without the EMR. Our current experience with QuadraMed, as well as escalating costs to maintain eight different EMR systems are compelling reasons why HHC has pursued this Negotiated Acquisition.

The healthcare marketplace is gearing up for Accountable Care. This transformation will require care coordination and clinical efficiencies that is supported by robust information systems. If HHC is to the meet these upcoming challenges we must have a fully integrated system of care; one which connects centers of excellence and one which can adapt quickly. Changes to our current system take months if not years to complete. There are cost implications of not making this investment as well. HHC has been approached by our incumbent EMR vendor because the vendor does not have enough resources to work on both eligible provider meaningful use AND Stage II at the same time. HHC will be able to sustain Stage I and II for Hospitals with the current system. However, the long term ability of the vendor to support stage II and Eligible providers is unclear. The financial impacts of not meeting meaningful use are estimated at $70 million for Eligible Providers (EPs) and Stage III will be worth approximately $40 million. In addition to risks to incentive funding, there are also risks of Medicare penalties (1% of total Medicare revenues in 2015, which is approximately 9.6 million dollars) for not maintaining meaningful use.

Through this Negotiated Acquisition, HHC will procure a new state of the art Electronic Medical Record solution that will increase patient safety through the use of efficient and effective decision support; that is scalable to the size and performance requirements of HHC, is able to meet the unique requirements and workflows of facilities and programs throughout HHC, is focused on secondary uses of data to improve patient care and outcomes; conforms with emerging and evolving HIT standards, and utilizes modern technology to allow for interoperability with foreign systems, RHIO's and other providers. The system will also streamline care delivery and eliminate waste and manual processes. Each of these will, in turn, optimize care experiences for patients, care providers and staff.

The ICIS EMR Project will be implemented at all eleven (11) HHC acute care hospitals, five (5) long term care/long-term acute care hospitals, six (6) diagnostic and treatment centers and over seventy (70) other community based clinics. More than 8,000 physicians, 2,500 residents, 9,000 nurses, and many other clinical professionals will directly interact with the ICIS system on a daily basis and nearly all 39,000 of HHC's dedicated employees will be impacted by the new clinical system as well as the 1.3 million patients served annually by HHC. The ICIS solution will be an integrated EMR utilizing a single database within a single data repository. The application environment will cover all clinical and supporting service lines within the acute care, long term care, and hospital-based and non-hospital-based ambulatory care settings. It will integrate with other existing HHC clinical and enterprise applications and will have extensive business intelligence/reporting functionality. The solution will be implemented within a scalable highly-available environment with full disaster recovery capabilities to minimize downtime.

The existing EMR used at HHC is a legacy system, which has a decreasing market share and has shown several changes in ownership (HDS, Medaphis, Per Se, Misys, and now QuadraMed). In 2006, HHC reviewed the state of our current EMR in the marketplace. It found there was significant executive turnover inclusive at the CEO level, minimal new client sales during the previous two years, the product had not kept pace with competition and competitive products had surpassed the incumbents' medical record functionality. Most recently, the lack of sufficient vendor resources was evident in the extended process leading to meaningful use.

In 2008, HHC planned and initiated a Negotiated Acquisition for a new Electronic Medical Record and received proposals from nine vendors, which were narrowed to five vendors after prequalification in 2009: Allscripts, Cerner, Epic, McKesson and Siemens. Subsequently, the Federal Government announced Meaningful Use incentive funding. HHC estimated total potential incentives at $125,000,000 for hospital program. In 2010, HHC began preparing for Meaningful Use attestation with the incumbent system to avoid potential loss of incentive funding. In August 2011, the five vendors were narrowed to three after initial ratings based on vendor functionality and gap analysis: Allscripts, Cerner, & Epic. Finally in mid-2012, HHC concluded that Epic offered the best proposal with the most integrated functionality. The contract costs are $ 215.4 million over the initial ten-year term and one $87.4 million five-year renewal option, for a total contract amount not to exceed $302,807,986.

CONTRACT FACT SHEET(**continued**)

Contract Review Committee
Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

August 22, 2012

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

N/A

Selection Process:

Please see Attachment A for list of selection committee members and firms that responded to NA.

The Negotiated Acquisition for a new integrated clinical information system has been carefully designed to maximize stakeholder input with a focus on transparency and process integrity. In 2008, HHC planned and initiated a Negotiated Acquisition for a new Electronic Medical Record and received proposals from nine vendors. HHC selected five leading vendors in 2009 during the prequalification phase followed by evaluations of the remaining vendors' full proposals. Through this comprehensive review process, the Selection Committee, (consisting of three Corporate Officers; Sr. Clinical Leadership representing Nursing, Medicine, Psychiatry, Long Term Care, Emergency Department, Informatics, and Pharmacy; along with the President's Chief of Staff, the Sr. Assistant Vice President of Finance and HHC's Chief Medical Officer), recommended two semi-finalists with one of them being the preferred vendor.

The Selection Committee was reconstituted in 2011 and met approximately twice monthly from July 2011 until April 2012. Member roles included (1) oversight of the selection activities; (2) review of key vendor documents, market research, and key proposal content; (2) review of progress reports; (3) review of quantitative ratings of integrated vendor demonstration scripts; (4) review of function-specific product evaluations by HHC's expert workgroups; and (5) review of analysis provided by the negotiating team. The Selection Committee has (6) recommended two vendors to proceed to final negotiation by the Negotiating Team to (7) review the results of the negotiation and (8) ratify and endorse the recommended vendor to the Corporation for ultimate consideration by the Board of Directors.

Expert Work Groups: To accomplish the detailed review of the software HHC engaged a broad representation of stakeholders from across HHC's Clinical Councils and other business units. Eight expert workgroups were assembled to review the vendors written responses with respect to system functionality. The workgroups reported directly to the selection committee and included approximately eighty individuals with experience managing and using electronic medical record systems. These workgroups are the same groups that contributed to the over 4,000 functional requirements questions contained within the request for full proposals. Expert Workgroups provided their observations of each vendor's strengths and weaknesses through formal presentations to the selection committee. In addition to attending vendor demonstrations, these groups conducted additional product reviews, attended site visits and participated in reference calls. Expert workgroups provided their impressions of system functionality to the Selection Committee for review, including any significant concerns.

The Negotiating Team has reviewed other aspects of the Full Proposals including the vendor's current financial position, ongoing vendor investment in research and development, review of the product roadmap, ability and willingness of the vendors to comply with HHC's standard contract terms and other key information contained within the full proposals, including the total cost. This group negotiated with the two semi-finalists and returned a final contract for consideration of the CRC.

Scope of work and timetable:

The scope of work includes procuring a comprehensive Integrated Clinical Information System (ICIS) to cover the majority of our Electronic Medical Records needs for all HHC facilities including Long Term Care, Acute Care Hospitals, and Ambulatory Care. The system chosen will provide electronic medical records functionality for all of these facilities and include a broad array of disciplines such as behavioral health, the emergency departments, obstetrics, as well as medicine, surgery, and subspecialties.

The following services will be provided through this contract:

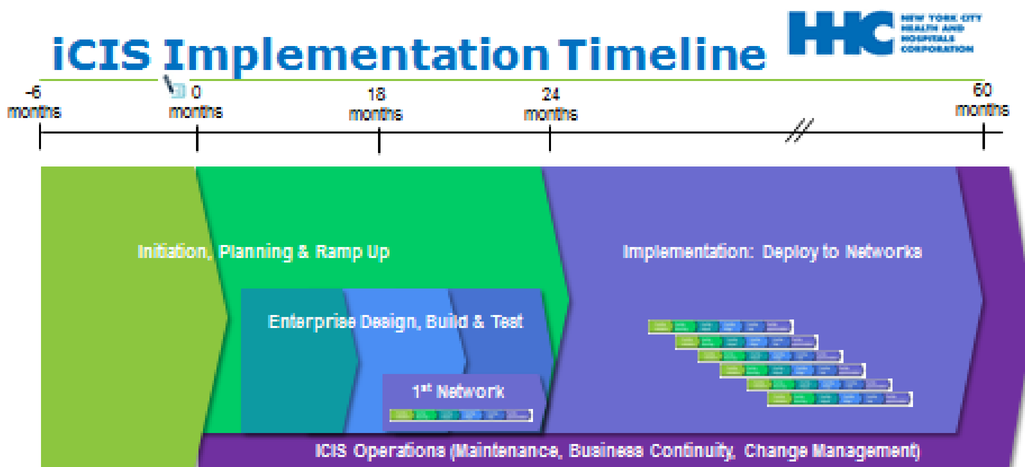
Software Licenses
- Perpetual Enterprise Licenses for all modules
- Third Party Licenses for Database and Supporting Applications

Software Maintenance
- Annual maintenance as modules are used

Professional Services
- Implementation support for the first wave hospitals, DTC, and LTC
- Technical Support during the implementation
- Training

The high level rollout timeframe is noted below:

The first network is scheduled to be implemented between the 18th and 24th month of the project.



Provide a brief costs/benefits analysis of the services to be purchased.

The Current level of QuadraMed spending, along with the new functionality that would be required to supplement the QuadraMed application, is significant. If HHC were to remain with QuadraMed, it would need to maintain over 90 existing applications and implement ten to fifteen major new applications.

Shown below is the fifteen-year software cost analysis performed to compare the proposed cost of software based on similar functionality. The analysis includes both of the Negotiated Acquisition finalist vendors: Allscripts and Epic. The outcome of this analysis, shown below, is that Epic was the best value due to the integrated functionality available in a single application. This allows HHC to use fewer applications to achieve the same functionality.

Epic	
Software, Training & Implementation Services	$ 83,469,164
Maintenance	$ 204,046,802
Contingency	$ 15,292,020
	$ 302,807,986

Allscripts	
Software, Training & Implementation Services	$ 90,574,028
Maintenance	$ 193,959,587
Contingency	$ 14,536,047
	$ 299,069,662

In addition, as part of the implementation of Epic, several well documented improvements are expected, particularly related to the transition of our Long Term Care facilities from paper to electronic:

Reduction in Lab Testing (5-16%)	*$ 336,000*
Saved Nursing Time with e-MAR	*$ 2,214,000*
Redeploy 6 FTE Record Room Staff	*$ 3,824,000*
Fifteen-year savings	*$ 6,374,000*

Provide a brief summary of historical expenditure(s) for this service, if applicable.

EPIC does not currently have any contracts with HHC.

The expenses for QuadraMed are referenced below:

	FY 12 *	FY 11	FY 10 **	FY 09
Software Licenses/ Maintenance	$ 9,210,779	$ 3,896,811	$ 7,363,674	$ 2,509,217

* includes new Meaningful Use components. Does not include e-RX.
**included large software upgrade payment.

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

A significant portion of the work of implementing the EPIC system will be performed by the Corporation's staff. However, the EPIC Vendor will provide necessary implementation support and training for HHC's staff to become independent and have the ability to maintain the system following implementation.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

No intellectual property creation is envisioned at the present time.

CONTRACT FACT SHEET **(continued)**

Contract monitoring (include which Senior Vice President is responsible):

Bert Robles
Senior Vice President
Chief Information Officer
Enterprise Information Technology Services

Louis J. Capponi, MD, FACP
Chief Medical Informatics Officer

Equal Employment Opportunity Analysis *(include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):*

Received By E.E.O.__May,2012__________
Date

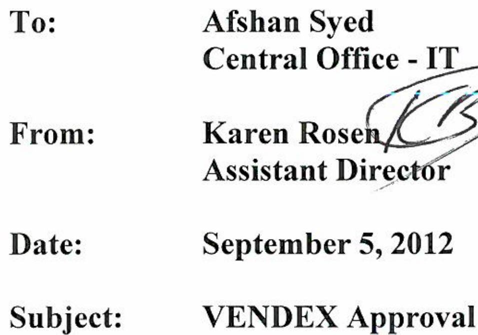
*Analysis Completed By E.E.O.*__Approved as of 5/10/2012
Date

By Manassas Williams__________
Name

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Room 527, New York, NY 10013 Tel: 212-788-3300 Fax: 212-267-6905
nyc.gov/hhc

Office of Legal Affairs

MEMORANDUM



To: **Afshan Syed**
Central Office - IT

From: **Karen Rosen**
Assistant Director

Date: **September 5, 2012**

Subject: **VENDEX Approval**

For your information, on September 5, 2012 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Epic Systems Corporation.

cc: Norman M. Dion, Esq.

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
125 Worth Street, Suite 401, New York, NY 10013 Tel: 212-788-3380 Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Patricia Cuartes
Information Technology Services

FROM: Manasses C. Williams m.c.w./D.P.

DATE: May 10, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Epic Systems Corporation,** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Various Hospitals

Contract Number: ________________ Project: Enterprise Software License

Submitted by: Office of Information Technology Services

EEO STATUS:

1. [X] Approved
2. [ ] Approved with follow-up review and monitoring
3. [ ] Not approved
4. [ ] Subject to EEO Committee Review

COMMENTS:

MCW/srf

EPIC Contract Presentation Summary

Background

In 2008, HHC determined that it needed to replace the current Electronic Medical Record (EMR) system and launched an initiative, code name iCIS, to replace the current fragmented and disconnected electronic health records with a new, state of the art system. iCIS - The Integrated Clinical Information System (iCIS) will be a single, standardized, enterprise-wide Electronic Medical Record that will build upon the Corporation's twenty years of experience using EMR's. One of the key goals of ICIS is to unite and connect all of HHC's hospitals, community based clinics long term care facilities, centers of excellence, and even our patients. ICIS will be a single, standardized, enterprise-wide Electronic Medical Record (EMR) that will meet HHC's need for an agile and dependable EMR for decades to come.

Utilizing the collective knowledge of our staff and based in Breakthrough improvement and industry-standard technology implementation and management methods, HHC will maintain its reputation for excellence as a safety net organization and continue the transformation into a "top notch" Accountable Care Organization. HHC's Accountable Care Organizations will require a highly developed Electronic Medical Record Systems to support complex care management and patient centered medical homes, manage cost, and eliminate waste while maintaining the best medical practice – in other words, to achieve the triple aim.

Over its twenty-year life span, the current EMR has enabled HHC to maintain operations and even improve in some areas. However, the current system has old functionality, such as clinical documentation and a decision support engine, which have not changed significantly for over 20 years. During that same time HHC's need, for this and other functionality, keeps growing. At this pace, HHC will be no match for the fast paced healthcare environment of the 21st Century. Other areas where the current EMR lacks functionality include the emergency department, operating room, long term care, behavioral health, patient portals, and mobile access. The system also lacks the agility to support our complex integrated delivery system. Finally, the vendor continues to have a low share of the EMR marketplace and falls below market expectations according to several industry authorities.

iCIS will be implemented across every Acute, Ambulatory and Long Term Care Facility including our 80 community-based clinics and all Behavioral Health areas (inpatient, outpatient, ED, mobile crisis, detox, etc). The advancements of iCIS will touch more than 8,000 physicians, 2,500 residents, 9,000 nurses and nursing staff, and other healthcare professionals. iCIS will be able to adapt to the changing needs in healthcare and meet Federal, State, and Local regulatory requirements. Being the central plexus for the entire Public Health Hospitals across all of the five boroughs in New York City , iCIS is being designed with full redundancy both locally (within each facility) and even across State lines to assure constant availability in the event of anything from a minor downtime to significant disaster. It will integrate with existing HHC enterprise applications for exchange of data and will support advanced extensive business intelligence and up-to-the minute dashboards and reporting functionality.

To put this in perspective, consider the case of Ms. Christie Jones. Ms. Jones is a 68-year-old female with a history of hypertension and angina who has recently suffered a small stroke. Previous to iCIS, the medical information regarding the care of Ms. Jones was contained in multiple systems making coordination of care difficult and validating the accuracy of her healthcare laborious. With iCIS, all of Ms. Jones' medical care will be captured within a single, robust, integrated EMR – from her arrival to the Emergency Department, admission as an Inpatient, and subsequent discharge, followed by care within the home and through the ambulatory care services, iCIS will allow all her medications, diagnostics and laboratory tests and clinical documentation to be readily available across HHC.

Ms. Jones is just one representation of the 1.2 million patients, often with even more complex medical conditions, who will benefit from the integrated EMR.

Selection Process

An EMR purchase of this magnitude requires an extensive, comprehensive, and detailed selection process to ensure that the new vendor and product align strategically with HHC. The EMR's evaluation criteria were divided into three major components: proposed system solution, strategic business partnership, and operational and financial impact.

1. **Proposed System Solution** – EMR must meet functional requirements, be intuitive and easy to use, support patient-focused care, provide 24/7 access to data, satisfy regulatory requirements, protect patient data privacy, and support health information exchange. Additionally, the vendor should not have failed implementations.

2. **Strategic Business Partnership** – Vendor compatibility based on integrity and reputation, focus on enterprise clinical solutions, alignment with HHC vision, proven implementation methodology, and track record in delivering success.

3. **Operational and Financial Impact** – Cost components include: software licensing & maintenance, hardware & technical infrastructure, implementation staging & resources, and total cost of ownership.

Participation

To achieve the goals of an endeavor of this magnitude, the engagement and collaboration of both clinical and administrative personnel was essential. HHC engaged a broad spectrum of participants who were representative of every facility type and nearly every service. Five groups to helped to evaluate the EMR vendors:

1. **iCIS Selection Committee** - The iCIS Selection Committee was composed of 15 members from HHC's senior leadership from the Networks and Central Office. The duty of this committee was to review the information gathered from the Demonstration participants and Expert Workgroup members and choose the EMR vendor that best fit HHC's needs.
2. **Expert Workgroups** – Eight Expert Workgroups were formed to review and evaluate each EMR's offering based on their extensive experience working at HHC and their experience with the

current EMR. Examples of expert workgroups include radiology, laboratory, and health information management.

3. **Demonstration Participants** – Consisted, on average, of approximately 120 clinical and 50 technical Network and Central Office staff members. The purpose of this group was to evaluate the initial two-day demonstration of the top five EMR vendors reviewed by HHC.
4. **iCIS Negotiating Team** – Formed by senior members of HHC Finance, IT, and Legal. This group reviewed and negotiated the terms and conditions of the two finalist EMR vendors.
5. **Councils** – Council members were kept abreast of the progress of the procurement at monthly council meetings which were attended by the iCIS team. These meetings were also used as an opportunity for engagement in some initial set of requirements gathering by the iCIS team.

Proposed System Solution

In June of 2011, five vendors were invited to a two-day clinical and technical session to review the functionalities of their EMR systems with HHC Participants. The five vendors were:

1. Allscripts
2. Cerner
3. Epic
4. McKesson
5. Siemens

Each vendor was provided an identical, detailed clinical scenario and asked to demonstrate their EMR's functionality based on this scenario. HHC participants scored each vendor's demonstration based on their performance in the demonstration and their ability to meet the clinical documentation requirements as per the scenario. In August of 2011, based on their performance and scores, the iCIS Selection Committee narrowed the number of vendors to three Finalists:

1. Allscripts
2. Cerner
3. Epic

From September 2011 to March 2012, members from HHC's Expert Workgroups conducted 33 additional review sessions with each finalist to evaluate their system on a more detailed granular level. These reviews included Clinical Documentation, Decision Support, Pharmacy, Laboratory, Ambulatory Care, Clinical Coding, Radiology, Peri-Op, HIM and Long Term Care. Technical reviews were also conducted to assess each system's ease of use and technological capability to support an organization as large as HHC. In addition to reviewing the EMR's functionalities, a small group of Expert Workgroup members attended two reference site visits per vendor to observe live systems at facilities similar in size and scope to HHC.

Strategic Alignment

Visits were also made by HHC's Executive Officers to each of the final three vendor's corporate headquarters. The purpose of these visits was to evaluate the alignment of the vendor's long-term strategic goals with HHC's long-term strategic goals.

Costs

Also during this period, a detailed analysis of each vendor's total cost of ownership (TCO) was conducted. The purpose of the TCO analysis was to evaluate all of the major components required to purchase and implement each EMR. In addition to each vendor's software costs, the TCO includes the additional software and accompanying hardware, interfaces and professional services required to install the new EMR throughout the Corporation. The evaluation of each vendor's costs was structured to provide equivalent comparisons between vendors ("apples-to-apples").

Final Evaluation

In April 2012, the iCIS Selection Committee evaluated each vendor based on the detailed reviews, Reference and Corporate site visits, and Total Cost of Ownership. The preferred finalist and alternate finalist were determined by the tabulation of structured scorecards which were filled out by each Selection Committee member. Based upon the scores, Epic was voted as the preferred finalist, Allscripts the alternate finalist. Negotiations began in parallel between HHC and each finalist shortly thereafter and continued through August 2012. After negotiations with the finalist vendors, the cost differences between each vendor were de minimis.

Based on extensive assessments of overall fit, goal alignment and cost, Epic was chosen as the finalist and presented to the Contract Review Committee meeting held on August 22nd, 2012.

The major advantages of choosing Epic include:

1. **One patient Electronic Medical Record across HHC.** Epic is able to extend its EHR functionality into essential clinical areas, such as behavioral health, anesthesia/operating room, emergency department and long term care and offer the only true INTEGRATED record.
2. **Integrates with the Soarian Financial System.**
3. **A Strong Company.** Epic is a privately held corporation with substantial growth and little debt. It has been used by large and complicated healthcare systems across the United States and has high ratings in the marketplace, including highest rated integrated EMR by KLAS, an industry authority on Health Information Technology ratings. Its business model consists of making their clients independent.

Many EPIC Customers have received recognition from the Health Information Management System Society (HIMSS) and received the prestigious Davies Award. More Epic Clients have achieved the highest stage of EMR functionality, Stage 7, than all other vendors combined. Research has correlated advanced IT systems with improved patient safety and also with improved financial performance. EPIC will provide HHC with the technology to continue our tradition of achievements in Health Information Technology.

Fifteen Year Cost Analysis

Today, HHC has over 130 clinical applications and many other clinical databases. This is a large number of clinical applications to manage. Even with this large number there remain significant gaps in several areas as noted earlier. These systems are often "stand alone," meaning they do not communicate with one another. Not only is the status quo failing to meet HHC's information system's needs, this large portfolio of stand alone applications is costly to maintain. HHC spends between $24 and $30 million per year on its main clinical systems and an additional $6 million annually for all of the stand-alone applications in use today. There are additional costs for infrastructure to run all of these applications. If we add to this estimate, the cost of procuring even more applications needed to fill the gaps of the status quo, the total fifteen year cost of ownership to maintain our current trajectory, including inflation, would be $1.28 billion over the next 15 years. This is compared to the total cost for the same time period to move to EPIC of $1.44 billion as detailed below.

The first item is the 15-year contract cost with Epic of $302.8M, which includes software licenses ($60M), professional services ($23.8M), software maintenance ($204M), and contingency ($15M). The software licenses include perpetual enterprise licenses for all modules and third party licenses for Cache database and pharmacy database. Professional services include implementation support for first three networks and training. Software maintenance is annual maintenance for the modules and includes 24x7x365 support. This cost also includes unlimited use of portals and PHR's for patients and the use of HIE communication via RHIO's. These cost components are outlined in Table 1

Table 1: 15-Year Epic Contract Cost

Item	Cost
Software Licenses • Perpetual Enterprise Licenses for all modules • Third Party Licenses for Cache Database & Pharmacy Database	$60 Million
Professional Services • Implementation support for first 3 Networks (including DTC and LTC) • Training	$23.8 Million
Software Maintenance • Annual maintenance for modules – paid when implemented	$204 Million
Contingency	$15 Million
Total	**$302.8 Million**

As referenced above, the total fifteen-year cost to migrate from the current trajectory to EPIC is $1.4B, which includes both new costs and the cost to maintain existing systems during the transition. A breakdown of these costs is shown in Table 2.

Table 2: Total Project Cost Analysis

Contract	Time Frame	15-Year Cost
Epic Contract	Term 2012-2027	$303 Million
QMED	Continuation of current contract through 2017	$80 Million
Third Party* Software	To be installed over the next 5 years and funded through 2027	$144 Million
Hardware*	To be purchased over the next 3 years and replacements to be funded through 2027	$191 Million
Interfaces*	To be purchased over the next 3 years and replacements to be funded through 2027	$157 Million
Implementation Support*	Vendors to be identified through RFP; includes cost of non-IT Staff participation, training and clinical staff coverage	$203 Million
Application Support Team	New and existing HHC Staff to be used through the implementation and maintenance period	$357 Million
Total		$1,435 Million

* Future contracts to be presented to the Board of Directors

Compared to the fifteen-year total cost of ownership of the current system, implementing the new Epic system results in a net cost of $157 million. This net increase is primarily due to implementation costs as well as the cost involved with transitioning from one system to another. The bulk of this cost difference can be funded by the CMS meaningful use incentive, which totals $125M.

Implementation

The iCIS Program is projected to be a five year implementation that will deliver an integrated clinical information system to each HHC acute care facility, diagnostic and treatment center and long term care facility. The Program will be structured according to the System Development Life Cycle (SDLC) standards and managed according to the processes defined by the Project Management Institute. The project plan will be developed collaboratively with key HHC stakeholders and the selected EMR vendor. To guide the direction of program work and establish a common understanding amongst team members, the following principles are set forth:

1. Provide strong clinical leadership and engage stakeholders throughout each phase of project
2. Maximize standardization by:
    - Establishing a strong governance structure
    - Following model content & best practice guidelines
    - Maintaining strict change control standards
    - Implementing one enterprise-wide database

By dividing the Program into phases, iCIS leadership will be able to effectively sequence and manage the broad scope and complexity of the Program. The iCIS Program will consist of four phases:

1. Initiation and Ramp Up - Ensure the appropriate planning is conducted and staffing levels defined
2. Enterprise Design and Build – The review, modification, and configuration of the vendor's out-of-the-box Model system to meet HHC's needs. The resulting product is the HHC Enterprise Model System, one that delivers standardized workflows and procedures throughout the Corporation.
3. Deployment to Facilities – The preparation for the installation and go-live of the new EMR at every HHC Facility.
4. Transition to Operations and Maintenance – The activities required to ensure a smooth transition to a fully operational and healthy electronic medical record system.

Governance

The Governance for this important project is currently being finalized. Strong project governance is one of the most critical components for success. The following are among the roles which will be established to ensure effective and timely decision making:

iCIS Executive Sponsor Committee – Provides overall Program oversight including governance and decision-making on key elements of the Program scope.

***iCIS Program Leader* -** The champion of the Program and provides Corporate-wide ownership. Has ultimate responsibility for the success of the Program in fulfilling its mission.

iCIS Program Director - Responsible for the overall planning, execution and control of the Program. Leads the Program Managers to mobilize and use the Program team to complete the Program successfully. Reports to the Program Leader.

***iCIS Program Management Team* -** Coordinates and monitors the execution of iCIS core activities and sub-project activities. M obilizes and uses the program team resources to complete the program successfully. Reports to the Program Director.

***HHC's Clinical Councils* -** Will be incorporated into the program to provide clinical guidance over the design and build of the HHC Enterprise Model system.

Budget Monitoring

Program spending will be monitored and regularly reported by the Program Director and Project Management Team to the Budget Director of IT as well the Executive Steering Committee, Corporate Finance and Budget, Capital, and other committees as appropriate. Careful attention to budget availability and cash flow will be required to ensure that the project remains on time and on budget.

Risk Management

Uncertain events or conditions may have a negative effect on the program's timeline and budget. Adequate risk management is a critical success factor of the iCIS Program. In order to develop effective mitigation plans and responses, multi-dimensional risks that are inherent in the program will be estimated and assessed with sufficient qualitative and quantitative analyses. The methodology and

process of managing program risks will be defined according to the Project Management Institute's Body of Knowledge.

Robust Technology with Disaster Recovery and Security

The infrastructure platform from which Epic will be run has been designed for high performance transaction speeds and high system availability. The proposed solution is the culmination of nine months of design and system capacity testing working directly with Epic and top tier hardware manufactures. A transaction speed service level agreement has been negotiated with all parties to assure medical staff will be able to perform their duties quickly and efficiently. The transaction speed estimates have been validated by performing specific system testing using a data set of similar size to what HHC can expect with Epic. Further the system includes instrumentation such that the transaction speed will be constantly monitored, allowing for action to be taken immediately if performance falls below present limits.

Each element of the system has been designed for high performance and reliability. The selected hardware includes all possible redundant componentry. Major system elements such as servers, storage, and network equipment have been arranged in a fault tolerant redundant configuration following industry best practices for high availability. In the event of interruption of one server the workload will move automatically to another piece of equipment with zero impact to the end user. The design includes a fully duplicated running system located in secondary data center, allowing for full system processing to be switched to a secondary facility within a 1 to 2 hour time frame with data loss of less than 1 minute.

Security is another major consideration for this robust system. Prior to selecting Epic, HHC's security and infrastructure team did a thorough review of all technical and functional security parameters enabled through this technology. The system will allow HHC to comply with HIPAA standards as well as Meaningful Use Certification Criteria. In addition, security features were evaluated to determine their level of flexibility to protect specific types of information including highly sensitive information.

Change Management

A key ingredient in the delivery of a quality solution is to ensure that all changes follow stringent change management procedures. The goal of the process is to ensure that standardized methods are followed for the efficient and prompt handling of all changes, minimizing the negative impacts of change. The change management process, when combined with other Information Technology Infrastructure Library (ITIL) standards-based processes, provides the necessary guidelines and procedures to efficiently apply changes to the system. Whether the change is to establish/update a configuration or fix a defect, the established Change Management Process will provide a consistent approach to the assessment of the impact of a change request, the associated risk, resources required, and approvals needed. A Change Management Board consisting of senior members of the Corporation will be instituted to review and approve high impact changes.

Communication

As with any large program, iCIS' success will depend on transparent and effective communications both within and outside the HHC community. The iCIS Program will provide regular, timely and appropriate communications to the various stakeholder audiences that relate to the program.

Integrated Clinical Information System

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The icis Project

EPIC Contract

2012

Contents

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

1. Background
2. Vendor Selection Process
3. Contract Terms and Cost Analysis

Background

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

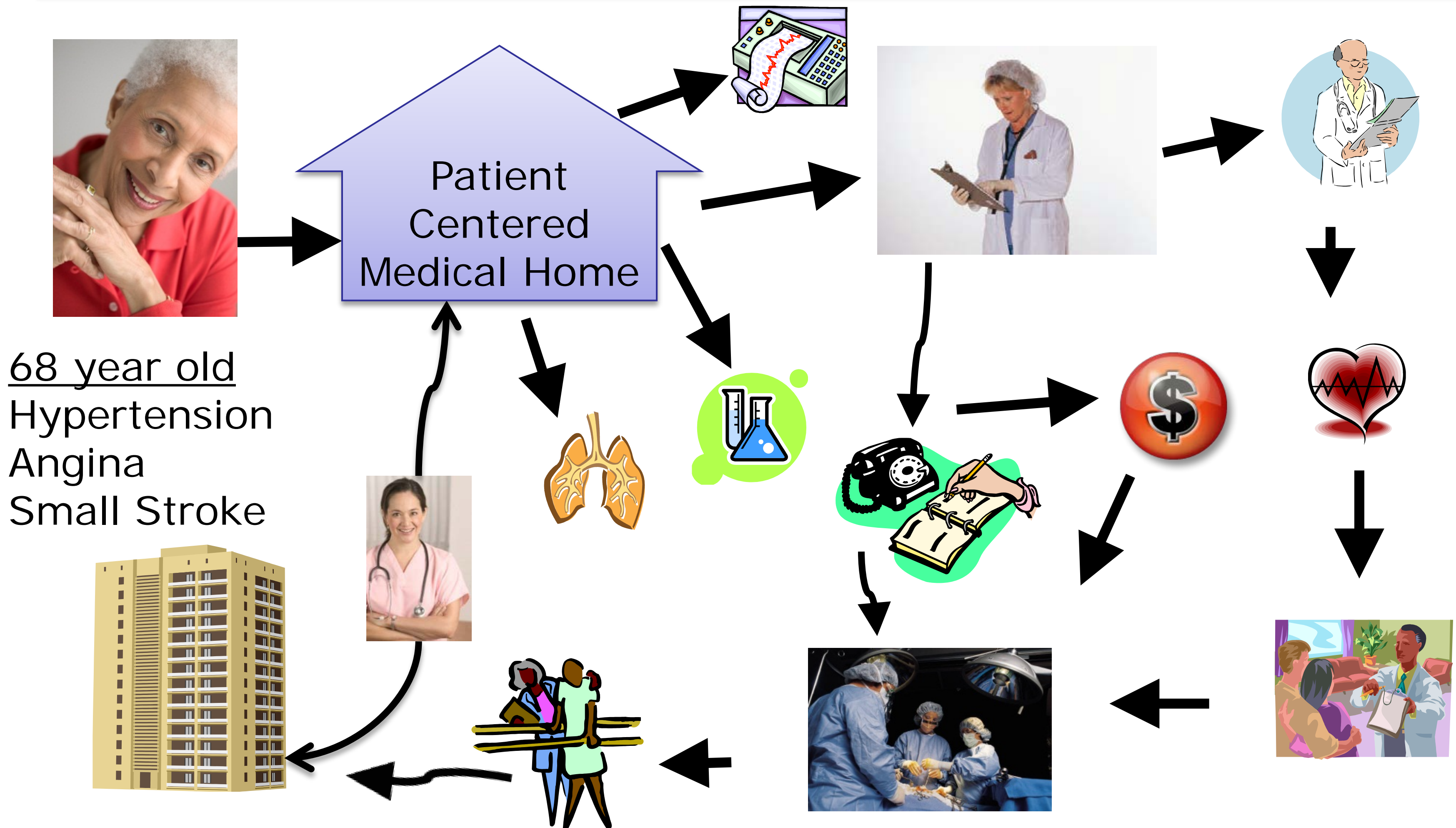
- Large Accountable Care Organizations like HHC require highly developed Electronic Medical Record Systems (EMR) to
  - support complex care management and patient centered medical homes.
  - achieve best medical practice.
  - manage cost and eliminate waste.

- The existing EMR vendor does not have the resources to support a complex integrated delivery system such as HHC.
  - The EMR lacks functionality in key areas (Clinical Documentation, Emergency Department, Operating Room, and Decision Support Systems).
  - The vendor continues to have a low share of the EMR marketplace.

Case Study: Christie Jones

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

This case illustrates the extensive coordination necessary to help Ms. Jones through one care process. Complex processes like this happen at HHC 100's of times each day.



A System to Run the System

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Older Electronic Health Records can't help HHC manage this complexity. HHC needs an Electronic Medical Record System to manage our Integrated Delivery System.

ICIS Selection Timeline

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

2008: Nine vendors submitted proposals for ICIS.

2009: February: After prequalification, the number of vendors were narrowed to five: Allscripts, Cerner, Epic, McKesson & Siemens.

2010: Full Proposal materials developed.

2011: May: Request for Full Proposal sent to five vendors: Allscripts, Cerner, Epic, McKesson & Siemens. 4,000 specific requirements reviewed.

June: Vendor presented demonstrations of their solutions . Selection committees began to meet (meetings continued through Summer 2012). Detailed reviews of vendor functionality and gap analysis were initiated (and continued through Spring 2012).

August: Based on initial ratings, the number of vendors were narrowed to three: Allscripts, Cerner & Epic .

2012: January: On-site visits were initiated, including: visits to evaluate scalability, hospital visits to view client installations, and visits to the corporate offices of Allscripts, Cerner, and Epic.

April: Based on functionality and cost, the number of vendors were narrowed to two: Allscripts (Alternate) & Epic (Preferred).

May: Contract negotiation sessions were held. TCO reviewed with Finance.

June-August: Documents assembled including: BAA, BAF, Vendex, EEO, CRC Application, Executive Summary, Resolution, and Contract fact sheet, Contract terms and conditions.

August: Finalist selected: Epic. CRC Meeting (8/22).

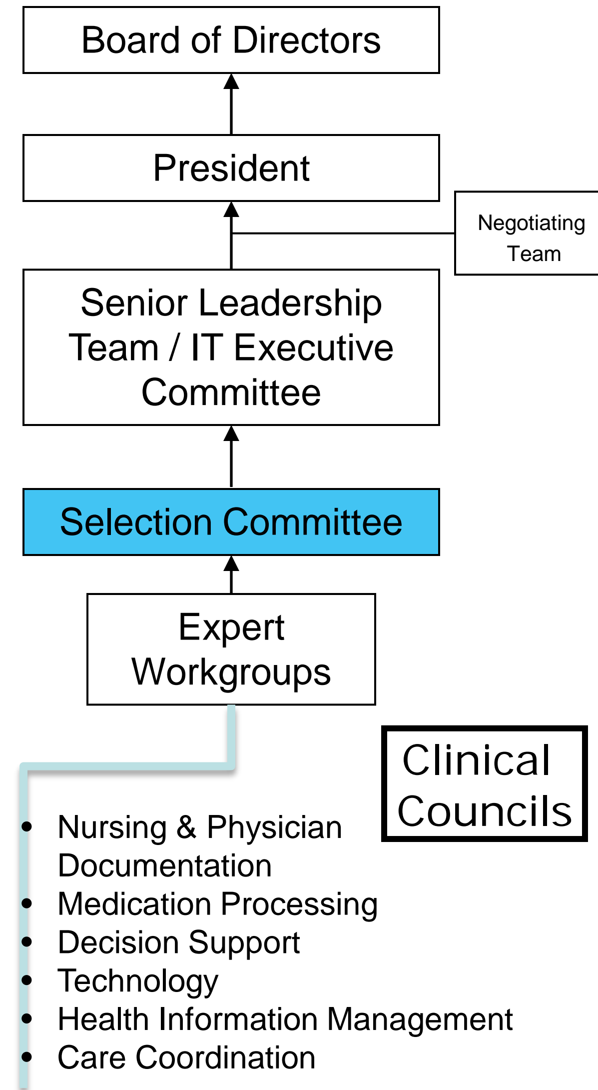
September: M&PA/IT meeting (9/20).
Full Board Meeting (9/27).

EWG = Expert Work Group
RFP = Request for Proposal
TCO = Total Cost of Ownership

The Selection Process

The selection process was extensive and inclusive. The Selection Committee members, listed below, ensured that the process was fair and complete.

Bert Robles	Co-Chair, SVP/CCIO
Dr. Ross Wilson	Co-Chair, SVP/CMO
Dr. Charles Barron	Dir. of Psychiatry, Elmhurst
Dr. Melissa Schori	Medical Director, Lincoln
Dr. Louis Capponi	CMIO
Maxine Katz	Sr. AVP, Revenue Management
Joann Gull, RN	Dir. of Nursing, Elmhurst
Lauren Johnston, RN	Chief Nurse Executive
Joseph Schick	Chief of Staff
Dr. Steve Kamholz	Chief of Medicine, Jacobi
Warren Lakoff	Dir. Pharm, Coney Island
Dr. Erick Legome	Dir. Emergency Dept. Kings Co.
Dr. John Maese	Medical Director, Coney Island
William Walsh	Sr. VP, North Bronx Network
Dr. Yolanda Bruno	Medical Director, Coler/GW



The Selection Process

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The key to our success in the selection process was extensive involvement by clinical staffs and highly detailed review of the vendor product.

- Early on, HHC conducted ten full days of scripted demonstrations. These demonstrations showed how the system would be used to care for patients specific conditions across multiple care settings.
- The review included over 100 review sessions, nine site visits, three system scalability tests in a test labs, and six executive visits.
- Overall, 312 HHC staff contributed input during the selection and review process.

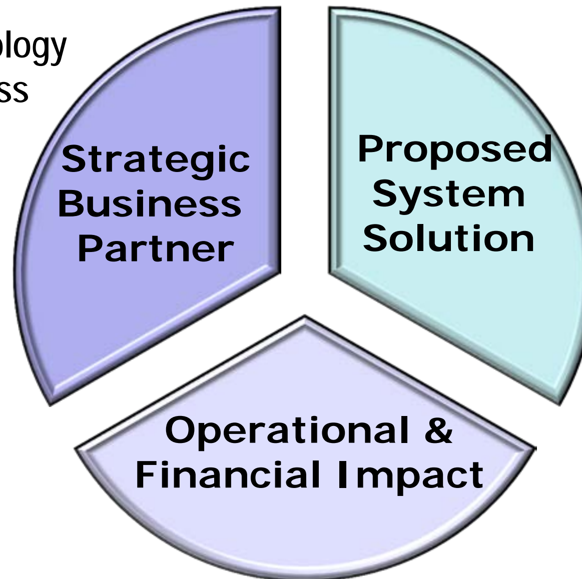
	Staff Participation	
Vendor	Clinical Sessions	Technical Sessions
Epic	147	52
Allscripts	98	54
Cerner	125	45
Siemens	111	46
McKesson	116	41

Selection Criteria Categories:

The selection process assessed three areas: Is this the right company; do they have integrated functionality; is the cost appropriate.

- Integrity and reputation
- Focus on enterprise clinical solutions
- Alignment with HHC vision
- Proven implementation methodology
- Track record in delivering success

- Meets functional requirements
- Is intuitive and easy to use
- Supports patient-focused care
- Provides 24/7 access to data
- Satisfies regulatory requirements
- Safeguards patient data privacy
- Supports health information exchange
- Vendor has no failed implementations



- Software licensing & maintenance
- Hardware & technical infrastructure
- Implementation staging & resources
- Total cost of ownership

Preferred Vendor: EPIC

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

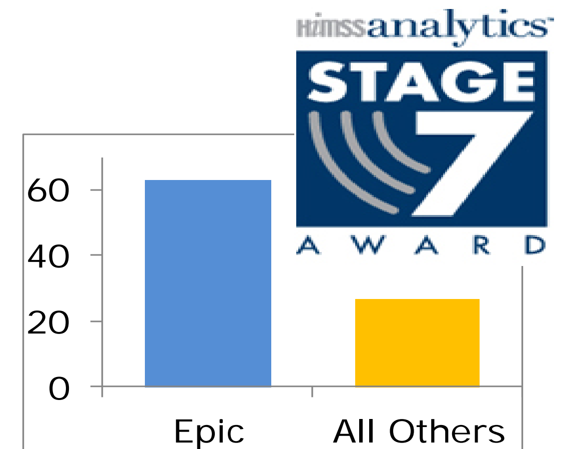
- One patient Electronic Medical Record across HHC
  - Extends EHR functionality into areas we need it:
    - Behavioral Health
    - Anesthesia/Operating Room
    - Emergency Department
    - Long Term Care
- Integrated with the Soarian Financial System
- A Strong Company
  - A privately held corporation with substantial growth and little debt
  - Used by large and complicated healthcare systems across the United States
  - Majority Women Owned Enterprise
  - High Ratings in the Marketplace

EPIC is Highly Rated

- Gartner, on of the world's top information technology research and advisory companies, consistently rates EPIC as a leader.

- EPIC is the highest rated integrated EMR in the marketplace by KLAS, an industry authority on Health Information Technology.

- The Health Information Management System Society (HIMSS) provides global leadership on the optimal use of Healthcare Technology. Stage 7 is their highest level of HIT achievement. Hospitals with greater HIT investment do better financially. More customers achieve stage 7 using Epic than all other vendors combined.



Large Hospital Systems Use EPIC

Name	City	State	Beds
Allina Health System	Minneapolis	Minnesota	2442
Bon Secours Health System	Marriottsville	Maryland	4397
Cambridge Hospital*	Cambridge	Massachusetts	270
Catholic Health Partners	Cincinnati	Ohio	6712
Cleveland Clinic	Cleveland	Ohio	3564
Geisinger Health System	Danville	Pennsylvania	700
Grady Health System*	Atlanta	Georgia	748
Harris County Hospital District*	Houston	Texas	757
Hennepin County Medical Center*	Minneapolis	Minnesota	416
Johns Hopkins Medicine	Baltimore	Maryland	2085
Kaiser Permanente - National	Oakland	California	8173
Louisiana State University	Baton Rouge	Louisiana	2190
MetroHealth System*	Cleveland	Ohio	529
Mount Sinai	New York	New York	1171
NYU	New York	New York	1000
Parkland Health & Hospital System*	Dallas	Texas	711
Providence Health and Services	Renton	Washington	6000
Sentara Healthcare	Chesapeake	Virginia	2350
SSM Health Care	St. Louis	Missouri	4006
Sutter Health	Sacramento	California	5618
Texas Health Resources	Dallas	Texas	4100
Weill Cornell Physicians	New York	New York	2236

* National Association of Public Hospitals & Health Systems (NAPH) Safety Net Members

EPIC Contract Cost – 15 Years

The 15 Year Contract cost is outlined below. Payments are fixed for the enterprise software licenses, milestone based for software maintenance, time-and-materials for professional services and training.

•Software Licenses	**$60 Million**
– Perpetual Enterprise Licenses for all modules	
– Third Party Licenses for Cache Database & Pharmacy Database	
•Professional Services	**$23.8 Million**
– Implementation support	
– Training	
•Software Maintenance	**$204 Million**
– Annual maintenance for modules – paid as implemented	
Contingency	**$ 15 Million**
	$ 302.8 Million

Project Cost Analysis

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The total fifteen-year cost to move from the current state to Epic is outlined below. This includes the cost of the new system as well as the cost to transition off the old systems.

Component	Description	15-year Cost (in millions)
1. EPIC Contract	Today's resolution Term 2012-2027	$303
2. QMED	Continuation of current contract through the transition	$80
3. Third Party & other Software *	To be installed over the next 5 years and to be funded through 2027. Includes transition of other existing applications.	$144
4. Hardware*	To be purchased over the next 3 years and replacements to be funded through 2027	$191
5. Interfaces*	To be purchased over the next 3 years and replacements to be funded through 2027	$157
6. Implementation Support*	Vendors to be identified through RFP, Includes cost of non IT Staff participation, training & clinical staff coverage.	$203
7. Application Support Team	New and Existing HHC Staff to be used through the implementation and maintenance period	$ 357
		Total: $1,435

* Future contracts to be presented to the Board of Directors.

Comparative Cost of Ownership Over 15 years

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The incremental cost to move to EPIC's Highly Integrated Clinical System is $157 million over fifteen years…

	EPIC	Legacy	Epic	Legacy
1. Software licenses, Maintenance, and Professional Services	$383 million	$ 375 million	(+) One integrated record (+) Used by many area hospitals (+) Robust decision support	(-) Disparate medical records (-) Low user satisfaction (-) Limited care coordination
3. Third Party, Gaps, and other existing applications.	$144 million	$ 393 million	(+) Fewer systems to maintain (+) Retire 90 applications	(-) Need 15 additional systems (-) Must retain 135 existing applications
4. Hardware, Peripherals & Disaster Recovery	$191 million	$ 170 million	(+) Fewer environments to test and maintain.	(-) Multiple separate environments to test and maintain.
5. Interfaces & related Professional Services	$157 million	$ 145 million	(+) Robust Biomedical instrument integration.	(-) Biomedical Integration limited. (-) Many systems cannot be sufficiently integrated to improve workflow.
6. Implementation Support	$203 million	$ 35 million		
7. Application Support Team	$357 million	$160 million	(+) Vendor trains client to be less dependent on consultants.	(-) Lack of available skills (-) Workforce spread thinner
	$1,435 million	**$ 1,278 million**		